Electronically Delivered

March 28, 2023

Licensee
Cornerstone Residence Senior Care
421 6th Street Northeast
Bagley, MN 56621

RE: Project Number(s) SL30775015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30775015 On February 27, 2023 through March 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 26 active residents; all of whom were receiving services under the Assisted Living wtih Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP)-G by disinfecting shared equipment in between residents use. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On February 28, 2023, at 8:36 a.m., the evaluator observed ULP-G monitor R3's blood pressure using an automatic blood pressure machine. After use, without disinfecting, ULP-G placed the automatic blood pressure machine on the medication cart. At 9:57 a.m., the surveyor observed ULP-G monitor R8's blood pressure using the automatic blood pressure cuff. After use, ULP-G placed the blood pressure cuff on the counter of the nurses station without disinfecting the equipment. On February 28, 2023, at 1:28 p.m., ULP-G	0 510		

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0 510	Continued From page 3 confirmed she had not disinfecedt the automatic blood pressure machine in between resident use and stated she should have. ULP-G stated she would normally use disinfectant wipes or disinfectant spray to sanitize shared equipment. On March 1, 2023, at 9:09 a.m., registered nurse (RN)-C stated the expectation was to disinfect shared equipment after each use by either using disinfecting wipes or spray. The licensees' Cleaning of Shared Medical Equipment policy dated August 1, 2021, indicated the licensee would implement and maintain processes to ensure all reusable resident care equipment would routinely be cleaned, and when appropriate, disinfected, before and after reuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days Surveyor: Umlauf, Sara J.	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 4 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) were developed to include the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension (high blood pressure), diabetes, and chronic obstructive pulmonary disease (COPD). R1's service plan dated November 8, 2022, indicated R1 received medication administration, oxygen therapy, blood glucose checks, assistance with bathing, toileting, housekeeping, and laundry. R2 R2's diagnoses included dementia with behavioral disturbances. R2's service plan dated December 9, 2022,	0 630		

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0 630	Continued From page 5 indicated R2 received medication administration, assistance with bathing, toileting, transferring, positioning, eating, behavioral interventions, housekeeping, and laundry. R3 R3's diagnoses included COPD, hallucinations, and hypertension. R3's service plan updated January 28, 2023, indicated R3 received medication administration, assistance with bathing, toileting, transferring, Tubigrips (elastic tubular bandages that provide support), wound care, oxygen therapy, nebulizer treatments, housekeeping, and laundry. R1, R2 and R3's IAPP dated September 30, 2022, March 3, 2023, and January 23, 2023, respectively, identified areas of vulnerability with interventions; however, lacked a review of R1, R2, and R3's risk of abusing other vulnerable adults, the risk of abusing others and the potential risk of self-abuse. On March 1, 2023, at 9:00 a.m., registered nurse (RN)-C confirmed the licensee's IAPP did not include all the required content noted above and would need to be added to the current IAPP. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the IAPP would contain susceptibility to abuse by another individual including other vulnerable adults and the person's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 27, 2023, at 10:30 a.m., during the entrance conference, the evaluator asked for a copy of the licensee's assisted living contract. The assisted living contract included a clause indicating the resident would waive the facility's liability for health, safety, or personal property of the resident. Pages nine (9) and 10, section 17.	0 970		

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0 970	Continued From page 7 Personal Property, of the assisted living contract indicated the resident agrees the provider is not responsible for any loss or damage to resident's personal property due to any reason or cause, including theft, other than provider's own negligence. Resident further agrees that provider is not responsible for damage to resident's personal property due to fire, water, tornado or other acts of nature and events beyond provider's control. Resident is strongly encouraged to obtain renter's insurance. On March 1, 2023, at 8:50 a.m., licensed assisted living director (LALD)-A confirmed the assisted living contract provided was the same contract used for all residents. LALD-A reviewed pages 9 and 10 of the contract, and further stated the administrator was responsible for updating and maintaining the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 8 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R5). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 9	01060		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R5 was admitted to licensee on April 30, 2019.

R5's service plan dated November 2, 2022, indicated R5 received medication administration, assistance with bathing, toileting, laundry and housekeeping.

R5's Emergency Relocation Notice Form dated November 28, 2022, indicated R5 was sent to the emergency room and was admitted for heart failure. The notice further indicated the notice was provided to the Office of Ombudsman for Long-Term Care; however, the form indicated the notice was not provided to the resident, legal representative and/or designated representative.

R5's record lacked documentation R5 or R5's designated representative received an emergency relocation notice with all required content.

On February 28, 2023, at 2:18 p.m., registered nurse (RN)-C confirmed the licensee had not been providing a relocation written notice to the residents and/or resident's representative and only had been notifying the ombudsman.

The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an

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01060	Continued From page 10 emergency relocation, the licensee would provide a written notice with the required content to the resident, legal representative, and designated representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 11 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

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01500	Continued From page 12	01500		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-F was hired on October 31, 2019, and began providing assisted living services on August 1, 2021.

On February 28, 2023, at 7:35 a.m., the evaluator observed ULP-F provide medication administration for R1.

ULP-F's employee record did not include the following required annual training:
-training on reporting of maltreatment of vulnerable adults under section 626.557

On March 1, 2023, at 8:50 a.m., licensed assisted living director (LALD)-A reviewed ULP-F's on-line training transcript and stated ULP-F did not complete the training on reporting of maltreatment of vulnerable adults.

The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff who perform direct care services will complete training elements every 12 months including training on reporting of maltreatment of vulnerable adults under section 686.557.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include the wound care for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01620		

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01620	Continued From page 14	01620		

isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R3's admission date was January, 23, 2023.

R3's diagnoses included chronic obstructive pulmonary disease (COPD), depression, hallucinations, and hypertension.

R3's service plan updated January 28, 2023, indicated R3 received medication administration, assistance with bathing, toileting, transferring, Tubigrips (elastic tubular bandages that provide support), wound care, oxygen therapy, nebulizer treatments, housekeeping, and laundry.

R3's prescriber orders included wound care ordered January 24, 2023, to coccyx ulcer to include removal of previous dressing, cleanse with normal saline, pat dry, apply collagen powder to wound bed, cover with foam bordered dressing every three (3) days and as needed if loose or excessive drainage.

R3's February 2023, Medication Sheet indicated R3 received assistance with wound care to coccyx ulcer every three (3) days.

R3's Comprehensive RN Assessment dated January 20, 2023, indicated R3's skin integrity had bruising on top of the hand; however, did not include R3's coccyx ulcer wound.

R3's 14- day Monitoring and Reassessment dated February 6, 2023, indicated R3's Comprehensive RN Assessment and service plan

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01620	Continued From page 15 were reviewed and there were no changes or updates. R3's 14-day Monitoring and Reassessment did not include R3's coccyx wound care. R3's Treatment and Therapy Management Plan dated January 23, 2023, did not include wound care. On February 28, 2023, at 12:28 p.m., RN-C stated she did not find out about R3's coccyx wound until after R3 was admitted and that was why R3's Comprehensive RN Assessment date January 20, 2023, did not include wound care. RN-C confirmed R3's 14-day Monitoring and Reassessment did not include wound care and should have triggered for RN-C to complete a new Comprehensive RN Assessment. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated ongoing reassessments and monitoring would be conducted by the RN as needed based on changes in the needs of the resident but could not exceed 90 days from the date of the last assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerators by failing to monitor and document medication refrigerator temperatures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 27, 2023, at 1:11 p.m., the evaluator reviewed the medication refrigerator located in the nurse's office with licensed practical nurse (LPN)-D. LPN-D stated the current refrigerator temperature was 41 degrees Fahrenheit (F). The refrigerator included the following medications: -10 unopened Lantus 100 units/milliliters (mL) insulin pens for R1 -2 unopened Trulicity 0.75 milligrams (mg)/0.5mL insulin pens for R1 On February 27, 2023, at 1:27 p.m., the daily medication refrigeration log posted on the front of the medication refrigerator was reviewed with LPN-D and she confirmed the temperature was recorded 17 times out of 26 daily opportunities for February 2023. LPN-D stated the temperature is	01880		

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01880	Continued From page 17 expected to be checked and recorded daily by staff. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Trulicity dated January 2017, indicated before opening store the pen in the refrigerator (36-46 degrees F). Do not allow Trulicity to freeze. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription	01890		

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01890	Continued From page 18 label with legible information including the expiration date for time sensitive medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 28, 2023, at 7:35 a.m., the evaluator observed unlicensed personnel (ULP)-F prime R1's open Lantus 100 units/milliliters (mL) pen (a multiple dose pen shaped injector device for insulin administration). ULP-F then handed the Lantus pen to R1, R1 dialed up the 70 units to be given on the insulin pen, verified with ULP-F and administered the insulin. R1's opened Lantus 100 units/mL pen did not have a label which indicted the date the pen had been opened and when the pen would expire. ULP-F confirmed the insulin pen did not include the date the pen was opened or when it would expire. ULP-F stated normally the ULP's would use a permanent marker and write the date on the pen it was opened. On February 28, 2023, at 9:04 a.m., licensed practical nurse (LPN)-D stated it is expected of staff to write the date the insulin pen was opened, and it would need to be discarded 28 days later. The manufacturer's instructions for Lantus insulin pens dated November 2018, directed to discard	01890		

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01890	Continued From page 19 the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Insulin and Subcutaneous Injections policy dated July 1, 2022, indicated when removing a new insulin pen from the box, print on the pen label the date opened as well as the expiration date following the manufacturer's instruction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of three oxygen storage areas. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	02310		

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02310	Continued From page 20 of staff are involved, or the situation has occurred only occasionally). The findings include: On February 27, 2023, at 3:05 p.m., the evaluator observed in the facility's training room a tall oxygen cylinder in the upright position against the counter. This oxygen cylinder was not stored securely in a holder. On February 27, 2023, at 4:21 p.m., clinical nurse supervisor (CNS)-B confirmed the oxygen cylinder was not stored properly. CNS-B stated all oxygen cylinders should be stored in a stand or rack and "(the oxygen cylinder) must have been missed." The licensee's Oxygen policy dated July 1, 2022, indicated oxygen cylinders must be stored in a secure stand or individual cart. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02350 SS=D	144G.91 Subd. 7 Courteous treatment	02350		

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02350	Continued From page 21 Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of one resident (R3) was treated with dignity and respect when unlicensed personnel (ULP)-G administered treatments to R3 in a public setting. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included chronic obstructive pulmonary disease (COPD), hallucinations, and hypertension. R3's service plan updated January 28, 2023, indicated R3 received medication administration, assistance with bathing, toileting, transferring, Tubigrips (elastic tubular bandages that provide support), wound care, oxygen therapy, nebulizer treatments, housekeeping, and laundry. R3's prescriber orders dated February 14, 2023, indicated R3's orders included budesonide 0.5 milligrams (mg) /2 milliliters (ml) one (1) vial two (2) times daily for COPD and formoterol 20 micrograms 2 ml one (1) vial by nebulizer two (2)	02350		

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02350	Continued From page 22 times daily for COPD. R3's Treatment and Therapy Management Plan dated January 23, 2023, indicated R3 received nebulizer treatments. R3's January and February 2023, Medication Sheets indicated R3 received budesonide and formoterol fumarate nebulizer treatments twice a day. On February 28, 2023, at 8:41 a.m., the evaluator observed ULP-G set up and administer R3's budesonide nebulizer treatment during breakfast time while R3 was sitting at the dining table with other residents present. On February 28, 2023, at 10:57 a.m., ULP-G stated R3's nebulizer treatments were completed in the dining room at the table per R3's preference and had questioned the evaluator if that was acceptable. On March 1, 2023, at 9:12 a.m., registered nurse (RN)-C stated it would be acceptable to administer nebulizer treatments in a public setting if the resident agreed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/28/23*
Time: 10:30:20
Report: 1002231035

Food and Beverage Establishment Inspection Report

Location:
Cornerstone Residence Snr Care
421 6th Street Ne
Bagley, MN56621
Clearwater County, 15

Establishment Info:
ID #: 0037664
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186942378
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-200B Food Characteristics:Receiving: temperature, condition

3-202.11D ** Priority 1 **

MN Rule 4626.0165D Discontinue sale or service of TCS hot food not received at a temperature of 135 degrees F (57 degrees C) or above.

CHICKEN NUGGETS AND MEATBALLS WERE RECEIVED BY THE ESTABLISHMENT FROM THE ATTACHED NURSING HOME KITCHEN AT TEMPERATURES OF 119 dF AND 109 dF, RESPECTIVELY. ITEMS WERE REHEATED IN OVEN AT TIME OF INSPECTION.

Comply By: 02/28/23

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

HALF GALLONS OF MILK AND CREAM IN BEV AIR COOLER WERE MEASURED TO BE 46 dF AND 43 dF, RESPECTIVELY. MDH DETERMINED THAT THIS WAS THE RESULT OF THE ITEMS BEING REMOVED FROM TEMPERATURE CONTROL FOR TOO LONG DURING BREAKFAST SERVICE.

Comply By: 02/28/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: DISPENSER @ 3 COMP SINK
Violation Issued: No

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: RESIDUAL CHLORINE CONCENTRATION - DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 43 Degrees Fahrenheit - Location: CREAM - BEV AIR COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 46 Degrees Fahrenheit - Location: MILK - BEV AIR COOLER
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 36-41 Degrees Fahrenheit - Location: COOKIE SALAD AND CHEESE - BEV AIR COOLER

Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: CHEESE - WALK IN COOLER
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - WALK IN FREEZER
Violation Issued: No

Process/Item: Receiving
Temperature: 156 Degrees Fahrenheit - Location: MECHANICAL DIET - PORK
Violation Issued: No

Process/Item: Receiving
Temperature: 179 Degrees Fahrenheit - Location: PORK LOIN
Violation Issued: No

Process/Item: Receiving
Temperature: 171 Degrees Fahrenheit - Location: CARROTS
Violation Issued: No

Process/Item: Receiving
Temperature: 119 Degrees Fahrenheit - Location: CHICKEN NUGGETS
Violation Issued: Yes

Process/Item: Receiving
Temperature: 109 Degrees Fahrenheit - Location: MEATBALLS
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	0

Discussed:

Handwashing

Employee illness

Safe cleaning, sanitizing and warewashing

Times and temps of TCS foods

Thermometer calibration - method and frequency

Note:
This establishment receives three meals per day from the attached nursing home. Meals are delivered at approximately 7:15 am, 11:15 am and 4:15 pm. Staff are required to take receiving temperatures to ensure proper hot and cold holding temperatures (135 dF or above for hot TCS foods/41 dF or below for cold TCS foods). At time of inspection, two separate hot TCS foods were measured to be less than 135 dF. Staff were instructed to reheat items to 165 dF prior to service.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1002231035 of 02/28/23.

Certified Food Protection Manager: Julie K. Sten

Certification Number: FM35131 Expires: 07/19/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kristi Girtz
Manager

Signed: _____
Cassandra Hua
Public Health Sanitarian III
218-308-2142
Cassandra.Hua@state.mn.us

Report #: 1002231035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	**Date**	02/28/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:30:20
Legal Authority MN Rules Chapter 4626		**Time Out**	

Cornerstone Residence Snr Care	**Address** 421 6th Street Ne	**City/State** Bagley, MN	**Zip Code** 56621	**Telephone** 2186942378
License/Permit # 0037664	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		COS	R
Safe Food and Water			
30	IN OUT N/A — Pasteurized eggs used where required		
31	Water & ice obtained from an approved source		
32	IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control			
33	Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O — Plant food properly cooked for hot holding		
35	IN OUT N/A N/O — Approved thawing methods used		
36	Thermometers provided & accurate		
Food Identification			
37	Food properly labled; original container		
Prevention of Food Contamination			
38	Insects, rodents, & animals not present		
39	Contamination prevented during food prep, storage & display		
40	Personal cleanliness		
41	Wiping cloths: properly used & stored		
42	Washing fruits & vegetables		

		COS	R
Proper Use of Utensils			
43	In-use utensils: properly stored		
44	Utensils, equipment & linens: properly stored, dried, & handled		
45	Single-use/single service articles: properly stored & used		
46	Gloves used properly		
Utensil Equipment and Vending			
47	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	Warewashing facilities: installed, maintained, & used; test strips		
49	Non-food contact surfaces clean		
Physical Facilities			
50	Hot & cold water available; adequate pressure		
51	Plumbing installed; proper backflow devices		
52	Sewage & waste water properly disposed		
53	Toilet facilities: properly constructed, supplied, & cleaned		
54	Garbage & refuse properly disposed; facilities maintained		
55	Physical facilities installed, maintained, & clean		
56	Adequate ventilation & lighting; designated areas used		
57	Compliance with MCIAA		
58	Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/28/23

Inspector (Signature)