Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 28, 2026

Administrator
Cornerstone Villa
1000 FOREST STREET
PO BOX 724
BUHL, MN 55713

RE: CCN: 245612
Cycle Start Date: December 4, 2025

Dear Administrator:

On January 23, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

January 28, 2026

Administrator
Cornerstone Villa
1000 FOREST STREET
PO BOX 724
BUHL, MN 55713

Re: Reinspection Results
Event ID: 1DC795-H2

Dear Administrator:

On January 23, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 4, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2025

Administrator
Cornerstone Villa

1000 FOREST STREET
PO BOX 724
BUHL, MN 55713

RE: CCN:245612
Cycle Start Date: December 12, 2025

Dear Administrator:

On December 04, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 4, 2026, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 4, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the

cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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December 12, 2025

Administrator
Cornerstone Villa
1000 FOREST STREET
PO BOX 724
BUHL, MN 55713

Re: State Nursing Home Licensing Orders
Event ID: 1DC795-H1

Dear Administrator:

The above facility survey was completed on December 4, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	1000 FOREST STREET PO BOX 724, BUHL, Minnesota, 55713

(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
E0000	Initial Comments On 12/1/25-12/4/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		01/12/2026
F0000	INITIAL COMMENTS On 12/1/25-12/4/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		01/12/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review	F0554	The policy for Self-Administration of Medications was reviewed, and appropriate All staff responsible for the administration of medications will be educated by the DON or their Designee on the policy for self- administration of medications The DON or their Designee will complete 3 random medication pass audits per wk for 3 weeks and then if	01/12/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0554 SS = D	Continued from page 1 the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 1 of 6 residents (R22) reviewed for medication administration. Findings include: R22's quarterly Minimum Data Set (MDS) dated 11/3/25, identified R22 had diagnoses which included unspecified open-angle glaucoma, severe stage. R22's care plan dated 11/17/25, identified R22 did not wish to self-administer medications. Interventions included nursing was to store, document, and administer all medications and treatments per the physician orders. R22's Order Summary Report identified the following orders: 9/4/19, atorvastatin calcium 40 milligrams (mg) by mouth for hyperlipidemia 10/17/25, Eliquis 5 mg by mouth one tablet twice daily for atrial fibrillation 7/21/23, folic acid 1 mg by mouth one time daily 10/31/25, furosemide 40 mg by mouth in the morning daily related to heart failure 10/31/24, iron 325 mg by mouth one tablet daily in the morning for anemia 10/2/25, lisinopril 30 mg by mouth one time a day for hypertension 11/13/24, pantoprazole 40 mg by mouth in the morning for gastroesophageal reflux disease During an observation on 12/2/25 at 9:56 a.m., registered nurse (RN)-A prepared R22's medications and brought them to his room. RN-A did not wait to ensure he took them and said he had a "SAM". A review of R22's electronic medication administration record verified he received the medications listed in orders on 12/2/25. A review of R22's self-administration record dated 11/3/25, identified the assessment was not completed. The section able to self-administer medications was marked as "no". The comments identified the following, "Resident does not wish to self-administer medications.	F0554	Continued from page 1 compliant reduce to weekly per month for three months. Recommended changes in processes and results of audits will be brought to QA for review. Corrected By: 01/12/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0554 SS = D	Continued from page 2 Nursing to store, administer, reorder and document all medications and treatments per orders." During an interview on 12/3/25 at 2:11 p.m., the director of nursing (DON) verified it would not be okay to leave a resident's medications at the bedside unless the resident had been assessed and care-planned for SAM. The DON stated it was important the resident understood why they were taking the medications and that they were reliable to take them. The Self-Administration of Medications policy dated 6/2017, identified staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident.	F0554		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for	F0641		01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0641 SS = A	Continued from page 3 each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code data on the Minimum Data Set (MDS) assessment for 2 of 2 residents (R3, R5) reviewed for MDS accuracy. Findings Include: R3's admission Minimum Data Set (MDS) dated 10/10/25, identified R3 was cognitively intact, and diagnoses included gastric reflux and osteoporosis. The MDS lacked a diagnosis of diabetes. The MDS section N: Medications identified R3 had received insulin one time during a 7-day evaluation period. R3's order summary report dated 12/3/25 lacked an order for insulin. During an interview on 12/1/25 at 2:18 p.m., R3 stated she was not a diabetic and had never taken insulin before. R5's annual MDS dated 10/27/25 indicated R5 was cognitively intact and diagnoses included heart failure and hypertension. The MDS lacked a diagnosis of diabetes. The MDS section N: Medications indicated R5 had received insulin one time during a 7-day evaluation period. R5's order summary report dated 12/3/25 lacked an order for insulin. During an interview on 12/2/25 at 9:18 a.m., R5 stated she was not a diabetic and had never taken insulin before. During an interview on 12/02/2025 at 1:08 p.m., registered nurse (RN)-C stated the data entered into the MDS was obtained from record review, medication review and talking with staff. RN-C reviewed R3 and R5's MDS reports and acknowledged insulin given was check marked on their most recent MDS assessments. RN-C reviewed R3's and R5's medical record and acknowledged neither R3 or R5 were diabetics and had never received insulin in the facility. R3 and R5 had received vaccines that week and insulin was marked accidently. During an interview on 12/02/2025 at 1:24 p.m., the director of nursing (DON) stated the MDS assessment is an accurate comprehensive look at the resident in question. The MDS needed to be accurate because the MDS was what built the care plan and let staff know how to care for the resident. The facility MDS policy was requested but not received.	F0641		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F0698	R1's care plan was reviewed and updated to reflect monitoring of the access site for signs and symptoms of infection and bleeding. Policies on the care and provision of services for	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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Cornerstone Villa	1000 FOREST STREET PO BOX 724, BUHL, Minnesota, 55713

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F0698 SS = D	Continued from page 4 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure post-dialysis access site monitoring was completed and documented to provide continuity of care and reduce the risk of complication (i.e., bleeding, clotting) for 1 of 1 resident (R1) reviewed for dialysis care and services. Findings include: R1's significant change Minimum Data Set (MDS) dated 8/1/25, identified R1 had a diagnosis of dependence on renal dialysis (a life-sustaining treatment for kidney failure that filters waste and excess fluid from the blood). R1's care plan dated 7/28/25, identified he went to dialysis Monday, Wednesday, and Friday. R1's dressing was to be changed daily with a site check, no blood draws or blood pressures on the right arm with the dialysis graft. In addition, staff were to monitor the site for signs and symptoms of infection and bleeding. (The care plan did not identify which site). R1's Order Summary Report dated 11/25/25, identified staff were to "monitor the right arm bruit (a consistent whooshing sound heard over an arteriovenous [AV] fistula or graft, indicating that blood is flowing properly) shiftly" and to call with concerns of hemorrhage, site infection, or hypotension. On 12/1/25 at 6:28 p.m., R1's door was closed with a sign up "NO VISITORS". The door remained closed throughout the survey. A review of R1's nursing notes from 11/25/25, through 12/4/25, did not identify any descriptions of R1's dialysis access site. On 12/3/25 at 10:07 a.m., nursing assistant (NA)- A stated R1 would return between 3:00 p.m. and 4:00 p.m. from dialysis. During an interview on 12/4/25 at 9:22 a.m., registered nurse (RN)-B stated she does not know when R1 returns from dialysis. RN-B stated she did not check the site upon his return on 12/3/25, but checked the bruit	F0698	Continued from page 4 individuals on Dialysis have been reviewed and updated as appropriate. DON or Designee to provide education to all staff responsible for assessing the Dialysis access site for signs and symptoms of infection, bleeding, and hypotension upon return of Dialysis DON or Designee to provide training and education to all staff responsible for responding to residents on dialysis on how to recognize and intervene in medical emergencies such as hemorrhages, infections, and the care of grafts and fistulas. DON or their Designee will audit documentation of residents returning from Dialysis weekly for 3 weeks to ensure compliance with documentation and then if compliant reduce audits to weekly per month for three months. Recommended changes in processes and results of audits will be brought to QA for review. Completed By: 01/12/2026	

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Cornerstone Villa	1000 FOREST STREET PO BOX 724, BUHL, Minnesota, 55713

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F0698 SS = D	Continued from page 5 before he left, RN-B stated this only needed to be done once per shift. RN-B verified there had not been any additional training by the facility for caring for residents receiving dialysis. During an interview on 12/4/25 at 10:07 a.m., the director of nursing (DON) verified the facility had not provided any additional training for staff regarding care of residents receiving dialysis and acknowledged it was a high-risk and low-volume population. The DON verified there was a concern for bleeding post dialysis and that was why site checks needed to be completed post dialysis. End-Stage Renal Disease, Care of Residents dated 01/2021, identified staff caring for resident receiving dialysis would be trained in the care and special needs of those residents. Education and training would include, how to recognize and intervene in medical emergencies such as hemorrhages and infections, and the care of grafts and fistulas.	F0698		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	The Director of Nursing reviewed the policy on medication administration and the control of narcotics have been found to be appropriate DON or their Designee will provide education to all staff responsible for medication administration on the facilities policies and procedures on medication administration and control of narcotics 3 random medication pass and cart audits will be conducted per wk for 3 weeks and then if compliant will reduce audits to weekly per month for three months. Recommended changes in processes and results of audits will be brought to QA for review. Completed By: 01/12/2026	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	1000 FOREST STREET PO BOX 724, BUHL, Minnesota, 55713

(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
F0761 SS = D	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medications including a narcotic were labeled and stored properly in 1 of 3 medication carts reviewed for medication storage. Findings include: During a medication cart inspection on 12/3/25 at 11:09 a.m., with the director of nursing (DON) a syringe with a pink fluid in it and a paper medication cup with one white pill were both in a plastic drink cup in the cubicle for R24. There were no labels on the syringe, paper cup, or plastic drinking cup. The DON verified this as well. During an interview on 12/3/25 at 11:17 a.m., the DON verified it was not appropriate to find any unlabeled medications in the medication cart. The DON stated she thought the pink liquid was morphine (a potent, opiate analgesic used to treat moderate to severe pain. It is a controlled substance). The DON stated morphine should not be prepared until the medication was ready to be given. In addition, the DON stated the morphine was no longer double locked. The DON verified the cubicle in the drawer was for R24. A review of R24's Order Summary Report dated 9/29/25, identified R24 had an order for morphine sulfate concentrate 100 milligrams (mg) per 5 milliliters (ml) with instructions to give 1 ml by mouth four times a day for pain. R24 also had an order for ondansetron 4 mg with instructions to give by mouth four times a day for nausea. During an interview on 12/3/25 at 11:26 a.m., registered nurse (RN)-B verified the medications were for R24 and the pink liquid was morphine and the white pill was ondansetron. RN-B stated both of the medications were scheduled and R24 had already left for the activity. RN-B stated it was her understanding they were not supposed to interrupt an activity to give a medication. RN-B verified she should have labeled both medications, and she should have locked the morphine back in the narcotic drawer. During an interview on 12/3/25 at 12:25 p.m., the consultant pharmacist (CP)-D verified he would expect a medication to be given after it was prepared. CP-D verified the medication (narcotic) should have been wasted if the resident was not available to receive it immediately. CP-D stated the concern was the narcotic was no longer double locked. The policy Administering Medications dated 12/2025, did not address labeling and storing medications that were not given as scheduled. The policy Controlled Substances dated 6/2017, identified controlled substances must be stored in the medication room or med cart in a locked container, separate from containers for any non-controlled medications.	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	All items expired or not labeled properly were	01/12/2026

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F0812 SS = F	Continued from page 7 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to dispose of expired food items. The facility also failed to label food items with the open date and expiration date. This had the ability to affect all 35 residents in the facility. Findings include: During the initial tour of the kitchen on 12/01/2025 at 1:30 p.m., a Yoplait yogurt container with an expiration date of 11/28/25, was observed in the walk-in refrigerator. There was also a clear plastic container with a green lid containing several hard-boiled eggs in the walk-in refrigerator. The container lacked a label with the items in the container, the date the hard- boiled eggs were prepared, and when the hard-boiled eggs needed to be disposed of. During an interview on 12/01/2025 at 1:44 p.m., culinary aide (CA)-A stated hard boil eggs are made on Saturdays and on Wednesdays. They would be prepared, peeled and then placed into a clear container with the lid. A label needed to be placed on the container with the item name, date prepared, and expiration date. All staff were responsible to make sure food used was not expired, and if so to dispose of	F0812	Continued from page 7 immediately removed from the refrigerator and disposed of. An audit of all refrigerators was immediately completed by the Culinary Director to ensure compliance with food safety standards. Staff were immediately educated by the Culinary Director on food safety protocols The Culinary Director implemented a daily audit of the main kitchen and kitchenette refrigerators and freezers All staff responsible for the labeling, dating and serving food will be educated by the Culinary Director or their Designee on the facilities policy and practice related to the safe handling of food safety requirements and standards. The Culinary Director or Deisgnee will be responsible for completing 3 random audits of the main kitchen and kitchenette refrigerators and freezers weekly for 3 weeks and if compliant reduce audits to weekly for 3 months. Recommended changes in processes and results of audits will be brought to QA for review. Completed By: 01/12/2026	

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F0812 SS = F	Continued from page 8 it. CA-A looked at the yogurt and acknowledged an expiration date of 11/28/25. CA-A was unsure when the yogurt was last served. CA-A also acknowledged the hard-boiled eggs had no label on the container. During an interview on 12/2/25 at 1:36 p.m., the culinary manager (CM) stated all food in the fridge should have a label on the container with the item's name, opened/made date, and expiration date. If the food item is at or past the expiration date when found, the item should be disposed of to decrease the risk of food borne illness. During an interview on 12/04/2025 at 8:38 a.m., the infection preventionist (IP) stated if expired or has no label then it needs to be disposed of. The label lets staff know what is in the container and if the food is still safe to consume. This decreases the risk of food borne illness. Facility policy Food Labeling and Dating undated, indicated all food would be labeled and dated accurately at the time of receipt, opening, or prepared. The facility would ensure all expired, improperly labeled, or undated food were immediately discarded. Prepared or cooked foods would be labeled and dated immediately after preparation. Held cooked food must be used or discarded within 72 hours for high-risk items such as proteins and dairy-based dishes.)	F0812		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/1/25 to 12/4/25, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		01/12/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.	20000		
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code data on the Minimum Data Set (MDS) assessment for 2 of 2 residents (R3, R5) reviewed for MDS accuracy.	20550	Corrected.	01/12/2026

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20550	Continued from page 2 Findings Include: R3's admission Minimum Data Set (MDS) dated 10/10/25, identified R3 was cognitively intact, and diagnoses included gastric reflux and osteoporosis. The MDS lacked a diagnosis of diabetes. The MDS section N: Medications identified R3 had received insulin one time during a 7-day evaluation period. R3's order summary report dated 12/3/25 lacked an order for insulin. During an interview on 12/1/25 at 2:18 p.m., R3 stated she was not a diabetic and had never taken insulin before. R5's annual MDS dated 10/27/25 indicated R5 was cognitively intact and diagnoses included heart failure and hypertension. The MDS lacked a diagnosis of diabetes. The MDS section N: Medications indicated R5 had received insulin one time during a 7-day evaluation period. R5's order summary report dated 12/3/25 lacked an order for insulin. During an interview on 12/2/25 at 9:18 a.m., R5 stated she was not a diabetic and had never taken insulin before. During an interview on 12/02/2025 at 1:08 p.m., registered nurse (RN)-C stated the data entered into the MDS was obtained from record review, medication review and talking with staff. RN-C reviewed R3 and R5's MDS reports and acknowledged insulin given was check marked on their most recent MDS assessments. RN-C reviewed R3's and R5's medical record and acknowledged neither R3 or R5 were diabetics and had never received insulin in the facility. R3 and R5 had received vaccines that week and insulin was marked accidently. During an interview on 12/02/2025 at 1:24 p.m., the director of nursing (DON) stated the MDS assessment is an accurate comprehensive look at the resident in question. The MDS needed to be accurate because the MDS was what built the care plan and let staff know how to care for the resident. The facility MDS policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure procedures MDS completion are being followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5	21100	Corrected.	01/12/2026

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21100	Continued from page 3 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to dispose of expired food items. The facility also failed to label food items with the open date and expiration date. This had the ability to affect all 35 residents in the facility. Findings include: During the initial tour of the kitchen on 12/01/2025 at 1:30 p.m., a Yoplait yogurt container with an expiration date of 11/28/25, was observed in the walk-in refrigerator. There was also a clear plastic container with a green lid containing several hard-boiled eggs in the walk-in refrigerator. The container lacked a label with the items in the container, the date the hard- boiled eggs were prepared, and when the hard-boiled eggs needed to be disposed of. During an interview on 12/01/2025 at 1:44 p.m., culinary aide (CA)-A stated hard boil eggs are made on Saturdays and on Wednesdays. They would be prepared, peeled and then placed into a clear container with the lid. A label needed to be placed on the container with the item name, date prepared, and expiration date. All staff were responsible to make sure food used was not expired, and if so to dispose of it. CA-A looked at the yogurt and acknowledged an expiration date of 11/28/25. CA-A was unsure when the yogurt was last served. CA-A also acknowledged the hard-boiled eggs had no label on the container. During an interview on 12/2/25 at 1:36 p.m., the culinary manager (CM) stated all food in the fridge should have a label on the container with the item's name, opened/made date, and expiration date. If the food item is at or past the expiration date when found, the item should be disposed of to decrease the risk of food borne illness. During an interview on 12/04/2025 at 8:38 a.m., the infection preventionist (IP) stated if expired or has no label then it needs to be disposed of. The label lets staff know what is in the container and if the food is still safe to consume. This decreases the risk of food borne illness. Facility policy Food Labeling and Dating undated, indicated all food would be labeled and dated accurately at the time of receipt, opening, or prepared. The facility would ensure all expired, improperly labeled, or undated food were immediately discarded. Prepared or cooked foods would be labeled and dated immediately after preparation. Held cooked food must be used or discarded	21100		

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21100	Continued from page 4 within 72 hours for high-risk items such as proteins and dairy-based dishes.)SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure food is labeled with an open and expiration date. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 1 of 6 residents (R22) reviewed for medication administration. Findings include: R22's quarterly Minimum Data Set (MDS) dated 11/3/25, identified R22 had diagnoses which included unspecified open-angle glaucoma, severe stage. R22's care plan dated 11/17/25, identified R22 did not wish to self-administer medications. Interventions included nursing was to store, document, and administer all medications and treatments per the physician orders. R22's Order Summary Report identified the following orders: 9/4/19, atorvastatin calcium 40 milligrams (mg) by mouth for hyperlipidemia 10/17/25, Eliquis 5 mg by mouth one tablet twice daily for atrial fibrillation	21565	Corrected.	01/12/2026

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21565	Continued from page 5 7/21/23, folic acid 1 mg by mouth one time daily 10/31/25, furosemide 40 mg by mouth in the morning daily related to heart failure 10/31/24, iron 325 mg by mouth one tablet daily in the morning for anemia 10/2/25, lisinopril 30 mg by mouth one time a day for hypertension 11/13/24, pantoprazole 40 mg by mouth in the morning for gastroesophageal reflux disease During an observation on 12/2/25 at 9:56 a.m., registered nurse (RN)-A prepared R22's medications and brought them to his room. RN-A did not wait to ensure he took them and said he had a "SAM". A review of R22's electronic medication administration record verified he received the medications listed in orders on 12/2/25. A review of R22's self-administration record dated 11/3/25, identified the assessment was not completed. The section able to self-administer medications was marked as "no". The comments identified the following, "Resident does not wish to self-administer medications. Nursing to store, administer, reorder and document all medications and treatments per orders." During an interview on 12/3/25 at 2:11 p.m., the director of nursing (DON) verified it would not be okay to leave a resident's medications at the bedside unless the resident had been assessed and care-planned for SAM. The DON stated it was important the resident understood why they were taking the medications and that they were reliable to take them. The Self-Administration of Medications policy dated 6/2017, identified staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure procedures for SAM were followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.	21565		

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21565	Continued from page 6 The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21615	MedicineCabinet & Preparation Area;ScheduleII CFR(s): MN Rule 4658.1340 Subp. 2 Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medications including a narcotic were labeled and stored properly in 1 of 3 medication carts reviewed for medication storage. Findings include: During a medication cart inspection on 12/3/25 at 11:09 a.m., with the director of nursing (DON) a syringe with a pink fluid in it and a paper medication cup with one white pill were both in a plastic drink cup in the cubicle for R24. There were no labels on the syringe, paper cup, or plastic drinking cup. The DON verified this as well. During an interview on 12/3/25 at 11:17 a.m., the DON verified it was not appropriate to find any unlabeled medications in the medication cart. The DON stated she thought the pink liquid was morphine (a potent, opiate analgesic used to treat moderate to severe pain. It is a controlled substance). The DON stated morphine should not be prepared until the medication was ready to be given. In addition, the DON stated the morphine was no longer double locked. The DON verified the cubicle in the drawer was for R24. A review of R24's Order Summary Report dated 9/29/25, identified R24 had an order for morphine sulfate concentrate 100 milligrams (mg) per 5 milliliters (ml) with instructions to give 1 ml by mouth four times a day for pain. R24 also had an order for ondansetron 4 mg with instructions to give by mouth four times a day for nausea. During an interview on 12/3/25 at 11:26 a.m., registered nurse (RN)-B verified the medications were for R24 and the pink liquid was morphine and the white pill was ondansetron. RN-B stated both of the medications were scheduled and R24 had already left for the activity. RN-B stated it was her understanding they were not supposed to interrupt	21615	Corrected.	01/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	**1000 FOREST STREET PO BOX 724, BUHL, Minnesota, 55713**

(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
21615	Continued from page 7 an activity to give a medication. RN-B verified she should have labeled both medications, and she should have locked the morphine back in the narcotic drawer. During an interview on 12/3/25 at 12:25 p.m., the consultant pharmacist (CP)-D verified he would expect a medication to be given after it was prepared. CP-D verified the medication (narcotic) should have been wasted if the resident was not available to receive it immediately. CP-D stated the concern was the narcotic was no longer double locked. The policy Administering Medications dated 12/2025, did not address labeling and storing medications that were not given as scheduled. The policy Controlled Substances dated 6/2017, identified controlled substances must be stored in the medication room or med cart in a locked container, separate from containers for any non-controlled medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff are trained on medication administration and control of narcotics. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/02/2025. At the time of this survey, Cornerstone Villa was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		01/12/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245612	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 1 B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cornerstone Villa is a one-story building without a basement that was built in 2003 and was determined to be of Type V(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system. There is a fire alarm system with complete corridor smoke detections, smoke detection in the spaces open to the corridor, and in the resident rooms. The fire alarm is monitored for automatic fire department notification. The skilled nursing facility shares a common two-hour fire-rated wall with an assisted living facility. The facility has a capacity of 44 beds and had a census of 39 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0346 SS = D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service	K0346	The Fire Protection Systems out of service policy that includes the Fire Alram out if service requirements was immediately reviewed and updated to reflect that the Fire Marshals Office would be contacted in the event that there was a fire alarm outage lasting longer than	01/12/2026

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K0346 SS = D	Continued from page 2 Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/02/2025 am 1229pm, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Facility Maintenance Director verified this deficient findings at the time of discovery.	K0346	Continued from page 2 4-hours in a 24 hr. period. The Policy now includes notifying the Fire Marshal. The Emergency Preparedness emergency contact list was updated to include in the contact list the name and phone number of the Fire Marshal The Administrator will ensure ongoing compliance with the standards of the regulation Date of Correction 12/02/2025.	
K0354 SS = D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	K0354	The Fire Protection Systems Out of Service Policy that includes the Sprinkler system out of service requirements was immediately reviewed and updated to reflect that the Fire Marshals Office would be contacted in the event that the Sprinkler system was out of service for more than 10 hours in a 24 hr. period, the building or portion of the building affected are evacuated or approved or an approved fire watch is provided until the sprinkler system has been returned to service. The Policy now includes the expectation of notification to the Fire Marshal. The Emergency Preparedness emergency contact list was updated to include in the contact list the name and phone number of the Fire Marshal The Administrator will ensure ongoing compliance with	01/12/2026

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K0354 SS = D	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire sprinkler system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/02/2025 at 1229pm, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Facility Maintenance Director verified this deficient findings at the time of discovery.	K0354	Continued from page 3 the standards of the regulation Date of correction 12/2/25	
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/02/2025 at 12:23pm, it was revealed by	K0355	The portable fire extinguishers had been inspected on 1/23/25 based on the standard. Documentation to support the inspection was not available at the time of the survey. The Director of Facility Maintenance obtained the appropriate documentation and will be responsible ongoing for the scheduling and confirmation of documentation to ensure compliance Correction Date 12/19/25	01/12/2026

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K0355 SS = D	Continued from page 4 documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K0355		
K0918 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. This deficient finding could have an isolated on the residents within the facility.	K0918	The facility scheduled testing of the reliability of the fuel in the generator from the contracted organization The fuel in the generator was tested on 12/5/25 The Facilities Maintenance Director has contracted on 12/4/25 with the vendor to add the annual fuel testing to the service plan. The facilities Maintenance Director will be responsible for ensuring that the testing of the fuel is completed annually to comply with the regulation Obtained Documentation: 12/19/2025	01/12/2026

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K0918 SS = D	Continued from page 5 Findings include On 12/02/2025 at 1224pm, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K0918		
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have a widespread impact on the residents within the facility.	K0921	A policy for the compliance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. was developed and implemented by the Facilities Maintenance Engineer The facilities Maintenance Engineer has catalogued service manuals, instructions and procedures for reference and maintenance and are readily available The Facility Maintenance Engineer or Designee as developed Safety labels and operating instructions and affixed them to the appropriate appliances The Facility Maintenance Director has developed a tracking system for the record of tests, repairs and modifications for patient care related electrical equipment Training in the testing and maintenance of electrical appliances has been developed, and the Facilities Maintenance Engineer or Designee will be responsible for oversight Bed Count Lifts Stands Bladder Scanner-1 Vital Sign Machines- 3 Manuals Completion Date: 01/12/2026	01/12/2026

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K0921 SS = F Bldg. 01	Continued from page 6 Findings include: On 12/02/2025 at 1250am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery	K0921		