DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 15, 2026

Administrator
Cornerstone Nsg & Rehab Center
416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

RE: CCN:245307
Cycle Start Date: July 7, 2026

Dear Administrator:

On July 7, 2026, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 October 7, 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 January 7, 2027 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 6, 2026

Administrator
CORNERSTONE NSG & REHAB CENTER
416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

RE: CCN: 245307
Cycle Start Date: July 7, 2026

Dear Administrator:

On July 30, 2026, the Minnesota Departments of Health 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING B. WING	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 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) COMPLETION DATE
E0000	Initial Comments On 7/6/26 through 7/7/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted. 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		07/15/2026
F0000	INITIAL COMMENTS On 7/6/26 through 7/7/26, a federal recertification survey (S5307041-0) was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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		07/15/2026
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order	F0699	The identified resident's Trauma-Informed Care Assessment was completed immediately upon identification of the deficient practice. The Social Services Designee reviewed the assessment findings, identified trauma history and potential triggers, and updated the resident's comprehensive care plan to include individualized trauma-informed interventions, as appropriate. The Social Services Designee completed a 100% audit of all current residents to verify completion of the	07/23/2026

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: 245307	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	**416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 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) COMPLETION DATE
F0699 SS = D	Continued from page 1 to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement a trauma-informed approach by failing to assess a resident's history of trauma upon admission and develop an individualized, person-centered care plan identifying trauma-related triggers and interventions for 1 of 1 resident (R1) reviewed for trauma-informed care. Findings include: R1's admission Minimum Data Set (MDS) dated 6/10/26, identified R1 had moderate cognition and required assistance with activities of daily living (ADL). R1 diagnoses included post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing a traumatic event), anxiety, and depression. R1’s care plan dated 6/4/26, failed include trauma-informed interventions, approaches to minimize triggers, or strategies to promote emotional safety. On 7/6/26 at 5:41 p.m., nursing assistant (NA)-A stated she was not aware that R1 had any interventions related to PTSD. NA-A stated the staff reviewed a resident’s care plan to identify if a resident had PTSD and what the triggers and interventions were needed when caring for the resident. On 7/7/26 at 8:45 a.m., R1 stated she had past trauma that caused bad dreams and affected her ability to fall asleep. R1 further stated staff had not asked about past trauma or potential triggers upon admission. R1’s medical record lacked evidence that a trauma assessment was completed upon admission to identify past trauma, triggers, or individualized care needs related to trauma history. On 7/7/26 at 9:35 a.m., the director of nursing (DON) stated the trauma informed care assessments were completed by the social worker for every admission. If the social worker was out of the office the administrator delegated the duties to another nurse. On 7/7/26 9:44 a.m., social services designee (SSD) stated the trauma informed care assessments were	F0699	Continued from page 1 Trauma-Informed Care Assessment. Any missing assessments identified during the audit were completed immediately, and the associated care plans were reviewed and updated to include individualized trauma-informed interventions, as indicated. The Social Services Designee, staff designated to provide Social Services coverage, and all nursing staff who participate in the admission process or complete admission observations will receive education regarding the facility's Trauma-Informed Care Policy and admission process. Education will include: Completion of the Trauma-Informed Care Assessment in accordance with facility policy, including upon admission, annually, and following identified actual or suspected trauma or when a reassessment is otherwise indicated. Identification and documentation of known or suspected trauma history, potential trauma triggers, emotional responses, resident preferences, and individualized care needs. Development of individualized trauma-informed interventions and incorporation of those interventions into the resident's comprehensive care plan. Responsibilities for completing or verifying required Social Services admission assessments when the Social Services Designee is unavailable to ensure continuity of the admission process. The facility reviewed and reinforced its Trauma-Informed Care Policy and admission process following identification of the deficient practice. The policy requires Trauma-Informed Care Assessments to be completed in accordance with facility policy, including upon admission, annually, and when actual or suspected trauma or other identified circumstances warrant reassessment. The admission process has been enhanced to clearly define responsibility for completion and verification of the Trauma-Informed Care Assessment for all new admissions. In the event the Social Services Designee is unavailable due to	07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	**416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 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) COMPLETION DATE
F0699 SS = D	Continued from page 2 completed as soon as possible for new admissions, annually and as needed with resident changes. Care plans were updated after assessments were completed and were important for staff to identify how to interact with the residents. SSD stated she was out of the office when R1 was admitted and when she returned SSD was unaware that R1 needed a trauma informed care assessment completed. SSD stated R1 should have had a trauma informed care assessment completed and potential triggers added to the care plan. On 7/7/26 at 10:00 a.m., the administrator stated trauma informed care assessments were completed by social services for each new admission or were delegated to nursing staff when social services were unavailable. The administrator stated when R1 was admitted, the social service assessments had been delegated to nursing staff; however, R1's TIC assessment was missed and not completed upon admission. The facility Trauma Informed Care Policy and Procedure reviewed 7/7/26, identified the facility would ensure that residents who were trauma survivors would receive culturally competent trauma informed care in accordance with professional standards of practice and considering residents experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. The policy further identified all residents would be screened for history of trauma and social information, and the interdisciplinary team would develop a person-centered care plan that addressed trauma informed care needs specific to each resident.	F0699	Continued from page 2 scheduled or unscheduled leave, designated Social Services coverage staff will assume responsibility for completing or verifying completion of all required Social Services admission assessments, including the Trauma-Informed Care Assessment. Nursing staff completing admission observations will document and communicate any known or suspected trauma history, potential triggers, emotional responses, resident preferences, or other pertinent observations to the Social Services Designee or designated coverage staff to facilitate completion of the Trauma-Informed Care Assessment and development of individualized trauma-informed interventions. The Administrator, or designee, will audit 100% of all new admissions to verify: Completion of the Trauma-Informed Care Assessment within the timeframe established by facility policy. Timely communication of pertinent findings identified during nursing admission observations to the Social Services Designee or designated coverage staff. Identification of trauma history and potential triggers, when applicable. Development and implementation of individualized trauma-informed interventions within the resident's comprehensive care plan, as appropriate. The Administrator, or designee, will review the records of all residents admitted during the previous week to verify compliance with the Trauma-Informed Care Assessment requirements. Audits will be conducted weekly for four weeks, followed by review of all new admissions every other week for an additional two months. Any identified deficiencies will be corrected immediately, and additional education will be provided as needed. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process. The facility will consider the corrective actions effective upon achieving and maintaining 100% compliance throughout the monitoring period.	07/23/2026