DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 37SC
Facility ID: 23242

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245612**
2.STATE VENDOR OR MEDICAID NO.
(L2) **884696100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX 724**
(L5) **BUHL, MN** (L6) **55713**

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **07/15/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathy Killoran, HFE NEII 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/12/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/16/2004
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/01/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5612

On July 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR), and on October 6, 2015 the Minnesota Department of Public Safety completed a PCR to verify that thefacility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June, 2, 2015 and a Federal Monitoring Survey (FMS) completed on June 6, 2015. Based on the revisit we have verified that the facility has corrected all the deficiencies as of July 30, 2015.

As a result of the PCR findings, this Department is recommending the following action to the CMS RO related to the remedy imposed in the CMS letter of June 24, 2015.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 2, 2015, be rescinded. (42 CFR 488.417(b))

Since the facility achieved compliance prior to DPNA going into effect, the facility is not subject to the NATCEP loss that was to begin September 2, 2015.

Refer to the CMS 2567b for health and FMS revisits.

Effective July 30, 2015 the facility is certified for 44 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245612

October 12, 2015

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street PO Box 724
Buhl, Minnesota 55713

Dear Ms. Doughty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 30, 2015 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 12, 2015

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street PO Box 724
Buhl, Minnesota 55713

RE: Project Number S5612013, F5612012

Dear Ms. Doughty:

On June 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 2, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 10, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 24, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 2, 2015 (42 CFR 488.417(b))

Also, the CMS Region V Office notified you in their letter of June 24, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 2, 2015.

On July 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 6, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued

pursuant to a standard survey, completed on June 2, 2015 and a Federal Monitoring Survey (FMS) completed June 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 2, 2015 and FMS completed June 10, 2015, effective July 30, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of June 24, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 2, 2015, be rescinded. (42 CFR 488.417(b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 2, 2015, is to be rescinded.

As you were advised in the CMS letter of June 24, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2015, 2015 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 30, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245612	A. Building B. Wing	7/15/2015

Name of Facility	Street Address, City, State, Zip Code
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**07/10/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**06/30/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**06/30/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**07/12/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**07/10/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**07/10/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	55!_ _	#' !#$!$' #	$+($	') !# !$' #

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
6/2/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

FMS

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245612	A. Building B. Wing 01 - MAIN BUILDING 1	10/6/2015

Name of Facility	Street Address, City, State, Zip Code
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 06/30/2015	ID Prefix Reg. # NFPA 101 LSC K0014	Correction Completed 07/10/2015	ID Prefix Reg. # NFPA 101 LSC K0015	Correction Completed 07/10/2015
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 06/30/2015	ID Prefix Reg. # NFPA 101 LSC K0022	Correction Completed 06/30/2015	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 07/30/2015
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 07/01/2015	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 07/02/2015	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 07/10/2015
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 07/10/2015	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 07/03/2015	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 07/10/2015
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 07/10/2015	ID Prefix Reg. # NFPA 101 LSC K0064	Correction Completed 07/03/2015	ID Prefix Reg. # NFPA 101 LSC K0076	Correction Completed 07/03/2015

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/12/2015	27200	10/06/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 37SC
Facility ID: 23242

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245612**

2.STATE VENDOR OR MEDICAID NO.
(L2) **884696100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX 724**
(L5) **BUHL, MN** (L6) **55713**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/02/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE
Cynthia Stramel, HFE NEII
Date : 06/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 06/29/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/16/2004
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 16, 2015

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street PO Box 724
Buhl, Minnesota 55713

RE: Project Number S5612013

Dear Ms. Doughty:

On June 2, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 12, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 2, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	**1000 FOREST STREET PO BOX 724 BUHL, MN 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
F 000	INITIAL COMMENTS 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		7/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/25/2015

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 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.

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to notify the physician of weight gains as ordered by the physician for 1 of 1 residents (R41) reviewed for dialysis. Findings include: R41's admission minimum data set (MDS) assessment dated 3/2/15 indicated the resident's diagnoses included end stage renal disease and heart failure, and received dialysis for management of renal failure. Renal care plan dated 3/31/15 were for 1500 milliliter fluid restriction daily and to be weighed on Monday, Wednesday and Friday before dialysis. The care plan also indicated the physican was to be notified for a weight gain greater than 2 pounds a day. A renal failure care plan indicated the resident went to dialysis on Monday, Wednesday and Friday and indicated the resident was on fluid restriction of 1500 milliliters daily. The following symptoms were to be monitored and reported to the physician: edema, weight gain of over 2	F 157	Cornerstone Villa strives to ensure that all changes in a resident's condition and/or status and the plan of treatment are promptly communicated to the resident's physician and family/representative. Corrective Action: Resident R41's weights/vital were taken per the resident plan of care - no changes were observed. Resident elected to stop dialysis on June 15th and elected, after discussion with Physician and family members, to receive comfort cares (hospice services were offered and were declined). Resident R41 died on June 18th. Corrective Action As It Pertains To Other Residents: All current residents will be reviewed for changes in condition and/or treatment. (There are currently no residents receiving dialysis services.) Those residents identified will be reviewed to determine if the physician and family were notified for the change. Those	

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F 157	Continued From page 2 pounds a day, increased heart rate and elevated blood pressure. The resident's weight record was reviewed from 3/1/15 to 6/1/15. There was no evidence R41 was weighed on the following physician ordered dates: 4/3, 4/6, 4/8, 4/15, 4/29, 5/1, 5/20, 5/22, 5/25 and 5/27/15. R41's 4/17/15, weight was 124.6, on 4/20/15, it was 127.2, a 2.6 pound gain. R41's 3/27/15, weight was 117.3, on 3/3015, it was 129.5, a 12.2 pound gain. The 3/2/15, weight was 119.9, on 3/4/15, it was 129.1, a 9.2 pound gain. There was no documentation the weights were rechecked and the physician had not been notified of the weight gain on the above dates. Interview with registered nurse (RN)-A on 6/2/15 at 8:50 a.m. indicated the resident was to be weighed before dialysis on Monday, Wednesday and Friday. RN-A indicated the weight variance may be discrepancies with scales or equipment on the wheelchair and the resident should have been reweighed. RN-A stated the physician should have been notified of the weight gains.	F 157	determined to require notification will be notified. This was completed on 6/25/2015. Change To Prevent Recurrence: Notification of Change in Condition Policy and Procedure was reviewed and updated on 6/16/2015. This policy and procedure was provided and reviewed at the staff inservice on 6/17/2015. Upon admission and thereafter, all residents receiving dialysis services will have the physician ordered weights and monitoring added to the TAR and the weight schedule will be added to the daily care sheets per the physician ordered intervals and entered into the resident record. The nurse will check to make sure that weights are taken when ordered, per the TAR and report all deviations per the physician orders and resident plan of care. Monitoring The Director of Nursing (or Designee) will audit 5 residents weekly for a change in condition. Those residents identified as having had a change in condition or treatment (injury, decline, significant weight gain/loss, etc.)will be reviewed to determine that the physician and family/representative have been notified. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued. Completion Date 7/10/2015	

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		6/30/15

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident elopement was reported to the state agency (SA) and thoroughly investigated for 1 of 1 residents (R44) reviewed for elopement. Findings include: R44's Admission Record identified diagnoses that included dementia with behavioral disturbance and depressive type psychosis. The quarterly Minimum Data Set (MDS) indicated R44 had severe cognitive impairment, and delusions, but no mood or behavior problems. The MDS also identified R44 required extensive assistance with staff for locomotion on and off the unit, and for dressing, personal hygiene, bed mobility, toileting and transfers. R44's care plan lacked interventions for elopement until 5/28/15, during the survey. On 2/5/15, an Elopement Risk Assessment was completed, and R44 did not display risk factors for elopement. No further Elopement Risk Assessments were completed. R44's Incident Reports identified the following: 3/18/15, at 11:35 p.m. R44 was attempting to leave the facility, and said he was going home to Hibbing. At that time a Wanderguard alarm (a system to alert staff if R44 was attempting to leave out the door) was placed on him. 5/3/15, at 10:30 a.m. R44 was found outside. A progress note indicated R44 was found outside by the end of the driveway. Staff reported she had	F 225	Cornerstone Villa that all alleged violations involving mistreatment, neglect, or abuse are properly reported and thoroughly investigated. Corrective Action: Resident R44's elopement was reported to OHFC/SA as well as St Louis County Common Entry Point. A full investigation of the incident was completed. An new elopement risk assessment was completed on 6/2/2015. The elopement risk assessment identified R44 as at risk for elopement. While a wanderguard alarm had been placed on the resident on 3/18/2015, this alarm was not entered onto the TAR to track the daily testing of the alarm - this was entered onto the TAR on 6/1/2015 at which time daily testing began. R44's plan of care was updated to include the elopement risk. Corrective Action As It Pertains To Other Residents: All residents have a current elopement risk assessment completed. Residents identified as at risk of elopement have an elopement care plan developed and initiated. Residents who have an wanderguard alarm placed have this noted on their TAR to ensure the device is checked nightly for proper working order. Physician and family/representatives have been notified of the risk and the plan of care. Changes to Prevent Recurrence:	

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F 225	Continued From page 5 seen R44 outside earlier with a visitor who was pushing him. Staff later noticed him alone and brought R44 in. The person who she had thought was pushing him was here visiting someone else, was only helping R44 navigate a curb in his wheelchair, and the visitor was unaware R44 was not to be outside alone. R44 was placed on 10 minute checks, and a stop sign was placed on the outside door. On 5/29/15, at 8:20 a.m. the director of social service (SS)-A stated R44's elopement had not been investigated, and the incident was not reported to the SA. On 5/29/15, at 9:12 a.m. the director of nursing (DON) stated R44's Wanderguard did not alert staff he was outside, it was not functioning, and a new Wanderguard was placed on him. The DON stated all Wanderguard systems are to be checked nightly to ensure they are functioning, however R44's Wanderguard had not been checked since it was placed on him on 3/18/15. The DON verified the incident had not been thoroughly investigated, and was not reported to the SA. The facility policy and procedure on Elopements dated 12/08, directed staff to investigate and report all cases of missing residents. The facility Abuse Prohibition policy and procedure dated 4/08, directs staff to investigate all incidents after they have been reported, and this information will be used to determine the appropriateness of reporting to the SA.	F 225	The Abuse Prevention Plan and the Elopement Policy and Procedure were reviewed and updated on 6/2/2015. Staff were inserviced on this plan (need to report to the SA, Administrator, Social Services and/or the Director of Nursing) on 6/17/2015 with emphasis on proper reporting and investigation. The revised plan/Policy was placed in all the Abuse Prohibition books. All new staff as well as residents and/or family/representatives will be given the revised plan/policies by 6/30/2015. Monitoring: The Social Services Director will review all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property, and elopements to ensure that these were properly and timely reported and that they are thoroughly investigated. The Administrator will audit 5 incident reports per week to determine if all reporting and investigation procedures have been carried out per the Abuse Prevention Policy and Procedure. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audit and determine if the audits will be continued, reduced, or discontinued. Completion Date: 6/30/2015	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		6/30/15

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F 226	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies and procedures were developed to report alleged incidents of elopement to the state agency (SA) and thoroughly investigate for 1 of 1 residents (R44) reviewed for elopement. Findings include: The facility Abuse Prohibition policy and procedure dated 4/08, directed staff to investigate all incidents after they have been reported, and this information will be used to determine the appropriateness of reporting to the SA. R44's Admission Record identified diagnoses that included dementia with behavioral disturbance and depressive type psychosis. The quarterly Minimum Data Set (MDS) indicated R44 had severe cognitive impairment, and delusions, but no mood or behavior problems. The MDS also identified R44 required extensive assistance with staff for locomotion on and off the unit, and for dressing, personal hygiene, bed mobility, toileting and transfers. R44's care plan lacked interventions for elopement until 5/28/15, during the survey. On 2/5/15, an Elopement Risk Assessment was completed, and R44 did not display risk factors	F 226	Cornerstone Villa strives to ensure all policy and procedures are up to date and are being properly carried out. Corrective Action: The facility Abuse Prevention policy and procedure dated 4/08 was reviewed and updated on 6/1/2015. The elopement policy and procedure was reviewed and updated on 6/1/2015. This update included first reporting is the proper state agencies and county common entry point and "then" investigating the incident. The Abuse Prevention Policy also included the requirement that the Administrator (or Designee)be immediately notified of the alleged incident or injury as well as the Physician, and family member/representative. Corrective Action As It Pertains To Other Residents: The revised Abuse Prevention policy and procedure as well as the revised elopement policy and procedure were presented to all staff at the 6/17/2015 inservice. This revised abuse prevention policy and procedure will be given/mailed to each resident and/or family/representative by 6/30/2015. Staff	

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F 226	Continued From page 7 for elopement. No further Elopement Risk Assessments were completed. R44's Incident Reports identified the following: 3/18/15, at 11:35 p.m. R44 was attempting to leave the facility, and said he was going home to Hibbing. At that time a Wanderguard alarm (a system to alert staff if R44 was attempting to leave out the door) was placed on him. 5/3/15, at 10:30 a.m. R44 was found outside. A progress note indicated R44 was found outside by the end of the driveway. Staff reported she had seen R44 outside earlier with a visitor who was pushing him. Staff later noticed him alone and brought R44 in. The person who she had thought was pushing him was here visiting someone else, was only helping R44 navigate a curb in his wheelchair, and the visitor was unaware R44 was not to be outside alone. R44 was placed on 10 minute checks, and a stop sign was placed on the outside door. On 5/29/15, at 8:20 a.m. the director of social service (SS)-A stated R44's elopement had not been investigated, and the incident was not reported to the SA. On 5/29/15, at 9:12 a.m. the director of nursing (DON) stated R44's Wanderguard did not alert staff he was outside, it was not functioning, and a new Wanderguard was placed on him. The DON stated all Wanderguard systems are to be checked nightly to ensure they are functioning, however R44's Wanderguard had not been checked since it was placed on him on 3/18/15. The DON verified the incident had not been thoroughly investigated, and was not reported to	F 226	were also provided with the "reportability for abuse under F225" decision making trees to assist them in determining what is reportable and who to report to. Changes to Prevent Recurrence: All new staff, residents, and/or representatives will be provided with the revised Abuse Prevention policy and procedure. Monitoring: The Social Services Director will review all incidents to determine if they were properly reported and investigated. The Administrator will audit 5 incidents per week to determine if allegations/injuries were reported per the policy and procedure and all were thoroughly investigated. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued. Completion Date: 6/30/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 8 the SA.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to monitor and notify the physician regarding weight changes as directed by the plan of care for 1 of 1 residents (R41) reviewed for dialysis. Findings include: R41's admission minimum data set (MDS) assessment dated 3/2/15 indicated the resident's diagnoses included end stage renal disease and heart failure, and received dialysis for management of renal failure. Renal care plan dated 3/31/15 were for 1500 milliliter fluid restriction daily and to be weighed on Monday, Wednesday and Friday before dialysis. The care plan also indicated the physican was to be notified for a weight gain greater than 2 pounds a day. The resident's weight record was reviewed from 3/1/15 to 6/1/15. There was no evidence that R41 was weighed on the following dialysis days: 4/15, 4/29, 5/1, 5/6, 5/8, 5/20, 5/22, 5/25 and 5/27/15.	F 282	Cornerstone villa strives to ensure that all weight and conditions are monitored and changes are communicated timely to the physician and family/representative in a timely manner. Corrective Action: Resident R41's weights were taken through 6/17/2015. Resident elected to stop dialysis on 6/15/2015 after discussion with the primary physician and family. Resident elected to receive comfort care (hospice services were offered and declined). Resident died on 6/18/2015. Corrective Action As It Pertains To Other Residents: All current residents will be reviewed for specific physician ordered and/or care planned monitoring. This monitoring will be entered onto the TAR as well as onto the resident daily care sheets (weights). Licensed Nursing staff will review the resident record/care sheet to ensure the information is recorded and to review the information for change in condition. If	7/10/15

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F 282	Continued From page 9 R41's 4/17/15, weight was 124.6, on 4/20/15, it was 127.2, a 2.6 pound gain. R41's 3/27/15, weight was 117.3, on 3/3015, it was 129.5, a 12.2 pound gain. The 3/2/15, weight was 119.9, on 3/4/15, it was 129.1, a 9.2 pound gain. There was no documentation the weights were rechecked and the physician had not been notified of the weight gain on the above dates. Interview with registered nurse (RN)-A on 6/2/15 at 8:50 a.m. indicated the resident was weighed before dialysis on Monday, Wednesday and Friday. She was unable to located the missing weights in R41's record. She further indicated the weight variance may be discrepancies with scales or equipment on the wheelchair and the resident should have been reweighed.	F 282	changes, per the physician orders and/or plan of care, are noted the physician and family/representative will be promptly notified. This was completed on ????. Changes To Prevent Recurrence: Notification of change in condition policy and procedure was reviewed and updated on 6/16/2015. All nursing staff were inserviced on 6/17/2015 on the policy and procedure as well as on the need to follow the resident plan of care as it pertains to monitoring weights, vitals, etc. Physician ordered monitoring will be added to the resident TAR upon receipt of the order. Weight schedule will be added to the CNA daily care sheets and will be entered into the resident record. Licensed Nurse will review the weights/information and will notify the physician of changes per the physicians order and residents' plan of care. Monitoring: The Director of Nursing (or Designee) will audit 5 residents weekly to ensure that the physician orders are being followed and that any changes are being promptly reported to the physician and family/representative. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued. Completion Date: 7/12/2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 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
F 309	Continued From page 10	F 309		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide necessary care and services for a dialysis patient related to obtaining accurate weights prior to dialysis and reporting abnormal weights to the physician for 1 of 1 residents (R41) reviewed for dialysis. Findings include: R41's admission minimum data set (MDS) assessment dated 3/2/15 indicated the resident's diagnoses included end stage renal disease and heart failure, and received dialysis for management of renal failure. Renal care plan dated 3/31/15 were for 1500 milliliter fluid restriction daily and to be weighed on Monday, Wednesday and Friday before dialysis. The care plan also indicated the physican was to be notified for a weight gain greater than 2 pounds a day A renal failure care plan indicated the resident went to dialysis on Monday, Wednesday and Friday and indicated the resident was on fluid	F 309	Cornerstone Villa strives to ensure that all resident receive the monitoring and oversight necessary to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being. Corrective Action: Resident R41's weights were taken through 6/17/2015 per her dialysis schedule - no abnormal weights were identified. Resident stopped dialysis on June 15th and elected, after discussion with Physician and family to receive comfort cares. Resident R41 died on 6/18/2015. Corrective Action As It Pertains to Other Residents: There are currently no resident receiving dialysis services. All residents have been reviewed for changes in condition requiring physician, resident and/or family/representative notification to ensure all have been notified. This was completed on 6/25/2015.	7/10/15

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	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 11 restriction of 1500 milliliters daily. The following symptoms were to be monitored and reported to the physician: edema, weight gain of over 2 pounds a day, increased heart rate and elevated blood pressure. The resident's weight record was reviewed from 3/1/15 to 6/1/15. There was no evidence R41's weights were completed on the following physician ordered dates: 4/3, 4/6, 4/8, 4/15, 4/29, 5/1, 5/20, 5/22, 5/25 and 5/27/15. R41's 4/17/15, weight was 124.6, on 4/20/15, it was 127.2, a 2.6 pound gain. R41's 3/27/15, weight was 117.3, on 3/3015, it was 129.5, a 12.2 pound gain. The 3/2/15, weight was 119.9, on 3/4/15, it was 129.1, a 9.2 pound gain. There was no documentation the weights were rechecked and the physician had not been notified of the weight gain on the above dates. Interview with registered nurse (RN)-A on 6/2/15 at 8:50 a.m. indicated the resident was weighed before dialysis on Monday, Wednesday and Friday. She was unable to located the missing weights in R41's record. She further indicated the weight variance may be discrepancies with scales or equipment on the wheelchair and the resident should have been reweighed. She also stated the physician was not notified.	F 309	Changes To Prevent Recurrence: The Policy and Procedure for Care Plan Need for Residents on Dialysis was reviewed and communicated to nursing staff on 6/17/2015. All residents receiving dialysis services will have a care plan developed that is individualized per each resident's needs and physician orders. Residents requiring increased weight monitoring (any other individualized monitoring) will have this monitoring added to their TAR as well as directions for reporting abnormal weights to the physician. The schedule in which weights will be obtained will be added to the resident daily CNA care sheets. The staff obtaining the weights will write them on the care sheet and will enter them into the residents' record. A licensed nurse will monitor the information and report to the physician and family/representative all abnormal losses/gains per the resident plan of care and physician orders. Monitoring: The Director of Nursing (or Designee) will audit 5 residents weekly (all residents receiving dialysis services) for a change in condition (including abnormal weights)to determine if the resident plan of care is being followed and to determine if the physician, resident and/or family/representative have been notified of any changes in condition or abnormal weights. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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F 309	Continued From page 12	F 309	be continued, reduced, or discontinued. Completion Date: 7/10/2015	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident elopement was thoroughly investigated for 1 of 1 residents (R44) reviewed for elopement. Findings include: R44's Admission Record identified diagnoses that included dementia with behavioral disturbance and depressive type psychosis. The quarterly Minimum Data Set (MDS) indicated R44 had severe cognitive impairment, and delusions, but no mood or behavior problems. The MDS also identified R44 required extensive assistance with staff for locomotion on and off the unit, and for dressing, personal hygiene, bed mobility, toileting and transfers. R44's care plan lacked interventions for elopement until 5/28/15, during the survey.	F 323	Cornerstone Villa strives to ensure that all residents remain free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Resident R44's elopement was reported to the SA (OHFC) as well as the St Louis County Common Entry Point. A full investigation of the incident was completed with the findings reported to the SA and family. An elopement risk assessment was completed on 6/2/2015. Care plan was updated, daily alarm testing was added to residents TAR. Corrective Action As It Pertains to Other Residents: All residents have a current elopement	7/10/15

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	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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F 323	Continued From page 13	F 323		

F 323 — Summary Statement of Deficiencies (continued):

On 2/5/15, an Elopement Risk Assessment was completed, and R44 did not display risk factors for elopement. No further Elopement Risk Assessments were completed.

R44's Incident Reports identified the following:

3/18/15, at 11:35 p.m. R44 was attempting to leave the facility, and said he was going home to Hibbing. At that time a Wanderguard alarm (a system to alert staff if R44 was attempting to leave out the door) was placed on him.

5/3/15, at 10:30 a.m. R44 was found outside. A progress note indicated R44 was found outside by the end of the driveway. Staff reported she had seen R44 outside earlier with a visitor who was pushing him. Staff later noticed him alone and brought R44 in. The person who she had thought was pushing him was here visiting someone else, was only helping R44 navigate a curb in his wheelchair, and the visitor was unaware R44 was not to be outside alone. R44 was placed on 10 minute checks, and a stop sign was placed on the outside door.

On 5/29/15, at 8:20 a.m. the director of social service (SS)-A stated R44's elopement had not been investigated.

On 5/29/15, at 9:12 a.m. the director of nursing (DON) stated R44's Wanderguard did not alert staff he was outside, it was not functioning, and a new Wanderguard was placed on him. The DON stated all Wanderguard systems are to be checked nightly to ensure they are functioning, however R44's Wanderguard had not been checked since it was placed on him on 3/18/15. The DON verified the incident had not been

F 323 — Provider's Plan of Correction (continued):

risk assessment completed. Staff were inserviced on 6/17/2015 with the revised Abuse Prevention Plan policy and procedure as well as the revised elopement policy and procedure. These revised policies and procedures included information pertaining specifically to elopement reporting to the Administrator (or designee), SA, St. Louis County Common Entry Point, Family/Representative, and the Physician as well as the requirement for the completion of a thorough investigation and the reporting of the results to the Administrator, Family/Representative, Physician and SA. Included in the Policy and Procedure is the Federal LTC Reportability Under F225 decision making trees. Current resident and/or family/representatives will be given the revised Abuse Prevention Policy and Procedure by 6/30/2015.

Changes To Prevent Recurrence:
The Abuse Prevention Plan as well as the Elopement Policy and Procedure were reviewed and updated on 6/2/2015 which includes direction for initial reporting, investigation, and reporting of results. All new staff, residents, and Family/Representatives will be given the revised Policy and Procedures.

Monitoring:
The Social Services Director will review all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property, and elopements to ensure that

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	245612	A. BUILDING ______ B. WING ______	06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 14 thoroughly investigated, and was not reported to the SA. The facility policy and procedure on Elopements dated 12/08, directed staff to investigate and report all cases of missing residents.	F 323	these were properly and timely reported and that they are thoroughly investigated. The Administrator will audit 5 incident reports per week to determine if all reporting and investigation procedures have been carried out per the Abuse Prevention Policy and Procedure. These audits will continue until the third quarter QA meeting at which time the committee will review the outcomes of the audits and determine if the audits will be continued, reduced, or discontinued. Completion Date: July 10, 2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5612011

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING ______	**05/27/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	**1000 FOREST STREET PO BOX 724 BUHL, MN 55713**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cornerstone Villa, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Cornerstone Villa is a one story building with no basement. It was constructed in 2004/2005. The construction type was determined to be Type V (111). The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 44 beds, the census was 42 at the time of inspection. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S & C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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 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.