DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 37SC PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 23242 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) CORNERSTONE VILLA (L1)245612 1. Initial 2. Recertification (L4) 1000 FOREST STREET PO BOX 724 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55713 884696100 (L5) BUHL, MN (L2)5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint (L9) 01 Hospital 05 HHA 13 PTIP 09 ESRD 22 CLIA 6. DATE OF SURVEY (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 07/15/2015 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 06/30 0 Unaccredited 1 TJC 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: **X** A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel __ 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN ___7. Medical Director 12. Total Facility Beds _1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size (L18) 5. Life Safety Code ___ 9. Beds/Room B. Not in Compliance with Program 13. Total Certified Beds 44 (L17) Requirements and/or Applied Waivers: * Code: (L12)A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)44 (L37) (L38) (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Kathy Killoran, HFE NEII 10/12/2015 Meath, Enforcement Specialist Mark 10/12/2015 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572)

X 1. Facility is Eligible to	RIGHTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)				_	
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT		26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY	
07/16/2004				01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)	(L25)		02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION	ONS		03-Risk of Involuntary Termination	<u>OTHER</u>	
	A. Suspension of Admission	ns:		04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	B. Rescind Suspension Da	(L44) te:			00-Active	
		(L45)				
28. TERMINATION DATE:	29. INTERME	DIARY/CARRIER NO.		30. REMARKS		
	03001	1				
	(L28)	(L3	31)			
31. RO RECEIPT OF CMS-1539	32. DETERMI	NATION OF APPROVAL DATE	Е			
	(L32) 07/01/20 1	15 (L3	33)	DETERMINATION APPROVAL		

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 23242

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

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

Cornerstone Villa October 12, 2015 Page 2

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 Meeth

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

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 245612	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/15/2015
Name of Facility		Street Address, City, State, Zip Code	
CORNERSTONE VILLA		1000 FOREST STREET PO BO	X 724

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
	F0157 483.10(b)(11)		Correction Completed 07/10/2015		F0225 483.13(c)(1)(ii)-(i		Correction Completed 06/30/2015		ID Prefix Reg. #	483.13(c)		Correction Completed 06/30/2015
LSC				LSC					LSC			
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 07/12/2015	ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 07/10/2015		ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 07/10/2015
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC				Reg. #			Correction Completed		ъ "			Correction Completed
ID Prefix Reg. # LSC				Reg. #					D "			
Reviewed E		/iewed	=	Date:	Signature	of Sur	veyor:				Date:	
State Agen	cy 55	5!		#"!#\$!\$"	#		\$+(\$!			")!፣	# !\$"#
Reviewed E	By Rev	/iewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comple 6/2/2015		:		Check for any Uncorrected					Summary o		NO

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 245612	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 1	(Y3) Date of Revisit 10/6/2015
Name of Facility		Street Address, City, State, Zip Code	
CORNERSTONE VILLA		1000 FOREST STREET PO BO BUHL, MN 55713	X 724

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	(14)	Item		(Y5)	Date
Reg. #	NFPA 101 K0012	Correction Completed 06/30/2015	Reg. #	NFPA 101 K0014		Correction Completed 07/10/2015		Reg. #	NFPA 101 K0015		Correction Completed 07/10/2015
ID Prefix Reg. #		Correction Completed 06/30/2015	ID Prefix Reg. #	NFPA 101 K0022		Correction Completed 06/30/2015		ID Prefix Reg. #	NFPA 101 K0025		Correction Completed 07/30/2015
Reg.#	NFPA 101 K0027	Correction Completed 07/01/2015	Reg. #	NFPA 101 K0029		Correction Completed 07/02/2015		Reg. #	NFPA 101 K0038		Correction Completed 07/10/2015
Reg.#	NFPA 101 K0048	Correction Completed 07/10/2015	Reg. #	NFPA 101 K0050		Correction Completed 07/03/2015		Reg. #	NFPA 101 K0056		Correction Completed 07/10/2015
	NFPA 101 K0062	Correction Completed 07/10/2015	Reg. #	NFPA 101 K0064		Correction Completed 07/03/2015		Reg. #	NFPA 101 K0076		Correction Completed 07/03/2015
Reviewed E State Agend Reviewed E CMS RO		Reviewed By GS/mm Reviewed By	Date: 10/12/20 Date:	Signature 15 Signature	27	200				Date:	6/2015
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

ID: 37SC Facility ID: 23242

]	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245612 2.STATE VENDOR OR MEDICAID NO.		3. NAME AND AL (L3) CORNERST (L4) 1000 FORES	ONE VILLA		.4	4. TYPE OF ACTIO 1. Initial 3. Termination	N: <u>2 (L8)</u> 2. Recertification 4. CHOW
(L2) 884696100		(L5) BUHL, MN			(L6) 55713	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNER (L9)	RSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY 06/02/2015 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of	The Following Requirement	ents:
To (b):			equirements		2. Technical Personnel	6. Scope of Ser	rvices Limit
	4 (T19)	•	e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Dir 8. Patient Roor	
12. Total Pacifity Beds 4.	4 (L18)	1. A	ecceptable FOC		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds 4.	4 (L17)	X B. Not in Com Requirement	npliance with Prog ents and/or Appli		_	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF 44	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS ((IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Cynthia Stramel, HFE NE	II	0	6/25/2015	(L19)	Mark Meath,	Enforcement Specia	06/29/2015 (L20)
				` ′	Mark Meath,		06/29/2015
	- TO BE (COMPLETED I		GIONAI	L OFFICE OR SINGLE S'	TATE AGENCY ncial Solvency (HCFA-257 ol Interest Disclosure Stmt	06/29/2015 (L20)
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible	- TO BE (te (L21)	COMPLETED I 20. COM RIGH	BY HCFA RE	GIONAI	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	TATE AGENCY notal Solvency (HCFA-257 ol Interest Disclosure Stmt	06/29/2015 (L20) 2) (HCFA-1513)
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participa 2. Facility is not Eligible 22. ORIGINAL DATE 23. L	- TO BE (20. COM RIGH	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	TATE AGENCY ncial Solvency (HCFA-257 ol Interest Disclosure Stmt	06/29/2015 (L20) 2) (HCFA-1513)
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participa 2. Facility is not Eligible 22. ORIGINAL DATE 23. L	- TO BE (te (L21)	20. COM RIGH	BY HCFA RE	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	TATE AGENCY Incial Solvency (HCFA-257) Interest Disclosure Stmt	06/29/2015 (L20) 2) (HCFA-1513) (L30) (TARY
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 07/16/2004	te (L21) TC AGREEM	20. COM RIGH	BY HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAT	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt	06/29/2015 (L20) 2) (HCFA-1513)
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE 23. L OF PARTICIPATION 15. O7/16/2004 (L24) (L24)	- TO BE (te (L21) TC AGREEN BEGINNING (L41)	20. COM RIGH	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to 1 06-Fail to 1	2) (HCFA-1513) (L30) VTARY Meet Health/Safety
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE 23. ELIGIBILITY OF PARTICIPATION IN 107/16/2004 (L24) (L24) (C25. LTC EXTENSION DATE: 27. A	- TO BE (te (L21) TC AGREEM BEGINNING (L41) ALTERNATIV	20. COMPLETED F 20. COMPLETED F RIGH MENT 24 DATE	BY HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAT	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to 1 m OTHER	2) (HCFA-1513) (L30) VTARY Meet Health/Safety
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE	- TO BE ((L21) TC AGREEN BEGINNING (L41) ALTERNATIV A. Suspension	20. COMPLETED E 20. COMPLETED E 20. ACCOMPLETED E 20. COMPLETED E 20. COMPLETE	3Y HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAT (L25)	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to 1 m OTHER	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE	- TO BE ((L21) TC AGREEN BEGINNING (L41) ALTERNATIV A. Suspension	20. COMPLETED F 20. COMPLETED F 20. A COMPLETED F 20.	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25)	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to N ement 06-Fail to N 07-Provide	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE	te (L21) TC AGREEM BEGINNING (L41) ALTERNATIV A. Suspension 3. Rescind Su	20. COMPLETED F 20. COMPLETED F 20. A COMPLETED F 20.	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to N ement 06-Fail to N 07-Provide	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II	te (L21) TC AGREEM BEGINNING (L41) ALTERNATIV A. Suspension 3. Rescind Su	20. COMPLETED F 24. Complete Service Se	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to N ement 06-Fail to N 07-Provide	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II	te (L21) TC AGREEN BEGINNING (L41) ALTERNATIV A. Suspension 3. Rescind Su:	20. COMPLETED I All STATE VE SANCTIONS of Admissions: spension Date:	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	EGIONAI I CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to N ement 06-Fail to N 07-Provide	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II - 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participal 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 07/16/2004 (L24) 25. LTC EXTENSION DATE: 27. A (L27) E 28. TERMINATION DATE:	te (L21) TC AGREEM BEGINNING (L41) ALTERNATIV A. Suspension 3. Rescind Suspension 29.	20. COMPLETED I All STATE VE SANCTIONS of Admissions: spension Date:	3Y HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAI (L25) (L44) (L45) (CARRIER NO.	GGIONAL I CIVIL MENT TE (L31)	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to N ement 06-Fail to N 07-Provide	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement
PART II - 19. DETERMINATION OF ELIGIBILITY	te (L21) TC AGREEM BEGINNING (L41) ALTERNATIV A. Suspension 3. Rescind Su:	20. COMPLETED I 24. COMPLETED I 24. COMPLETED I 24. COMPLETED I 25. COMPLETED I 26. COMPLETED	3Y HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAI (L25) (L44) (L45) (CARRIER NO.	GGIONAL I CIVIL MENT TE (L31)	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	TATE AGENCY Incial Solvency (HCFA-257 of Interest Disclosure Stmt INVOLUM 05-Fail to 10 06-Fail to 10 07-Provide 00-Active	2) (HCFA-1513) (L30) STARY Meet Health/Safety Meet Agreement



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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document:

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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

Cornerstone Villa June 16, 2015 Page 4

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.

Cornerstone Villa June 16, 2015 Page 5

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 Weath

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

PRINTED: 06/25/2015 FORM APPROVED

F 000 INITIAL COMMENT The facility's plan of as your allegation of Department's acceptenrolled in ePOC, you at the bottom of the form. Your electronic be used as verification on-site revisit of your validate that substant	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) FS of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance.	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP (1000 FOREST STREET PO BOX 72 BUHL, MN 55713 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION	(X5) COMPLETIC DATE
(X4) ID SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER) F 000 INITIAL COMMENT The facility's plan of as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verification on site revisit of your validate that substantices.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) FS of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance.	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP (1000 FOREST STREET PO BOX 72 BUHL, MN 55713 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION	(X5) COMPLETIO
F 000 INITIAL COMMENT The facility's plan of as your allegation of Department's acceptenrolled in ePOC, you at the bottom of the form. Your electronic be used as verification. Upon receipt of an an on-site revisit of your validate that substantices.	on of compliance.	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I CHOILL DE	COMPLETION
The facility's plan of as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verification-site revisit of your validate that substantia.	of correction (POC) will serve from the from the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance.	F 00	00		
Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verificating upon receipt of an a on-site revisit of your validate that substantic accepts the substantic acce	otance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance.				
F 157 483.10(b)(11) NOTIF SS=D A facility must immed consult with the resid known, notify the resion or an interested family accident involving the injury and has the pot intervention; a signific physical, mental, or pudeterioration in health status in either life thrullinical complications) significantly (i.e., a new existing form of treatment); or a decision the resident from the figure 150 must also r	racility may be conducted to attail compliance with the nattained in accordance with the nattained in accordance with TY OF CHANGES ROOM, ETC) diately inform the resident; ent's physician; and if ident's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a mental, or psychosocial eatening conditions or a need to alter treatment ed to discontinue an ment due to adverse commence a new form of on to transfer or discharge acility as specified in	F 157	7	7	7/10/15

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII T	IDI E CONOTRUCTION	OMB M	D. 0938-039 ²
WOI CONNECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DA	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER	245612	B. WING _		06/02/2047	
CORNERSTONE VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713	_ 06	6/02/2015
PRÉFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D DE	(X5) COMPLETION DATE
resident rights under regulations as specific this section. The facility must recomb the address and phore legal representative of the address and document of facility failed to notify the gains as ordered by the residents (R41) review as a sessment dated 3/2 diagnoses included en heart failure, and receing management of renal for the address and the address and the care plan physican was to be not greater than 2 pounds and indicated the restriction of 1500 millility restriction of 1500 millility and indicated the	commate assignment as (e)(2); or a change in Federal or State law or ied in paragraph (b)(1) of ord and periodically update the number of the resident's or interested family member. It is not met as evidenced the physician of weight the physician for 1 of 1 wed for dialysis. In um data set (MDS) (15 indicated the resident's distage renal disease and wed dialysis for failure. 3/31/15 were for 1500 daily and to be weighed ay and Friday before also indicated the iffied for a weight gain a day. In indicated the resident day, Wednesday and eresident was on fluid ters daily. The following nonitored and reported to weight gain of over 2			and/or re dident's exident section of the section o	

STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII TI	DI E CONOTDUOTION	OMB NO	D. 0938-0391
- Z IN OF COR	IVECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
NAME OF PROVID	FR OR SURDUED	245612	B. WING _			
CORNERSTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724	06	/02/2015
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		BUHL, MN 55713		
PREFIX (TAG R	LYCU DELICIENCA	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
pound blood The right was with the state of	esident's weight to 6/1/15. The sighed on the 4/3, 4/6, 4/8, 4/17/15, weight 27.2, a 2.6 pout was 117.3, on gain. The 3/2, it was 129.1, tumentation the physician had gain on the above with register a.m. indicated before dialyster discrepancies wheelchair and everythed. RN-2 weighed. RN-2	ased heart rate and elevated of trecord was reviewed from ere was no evidence R41 following physician ordered 4/15, 4/29, 5/1, 5/20, 5/22, at was 124.6, on 4/20/15, it and gain. R41's 3/27/15, a 3/3015, it was 129.5, a 12.2 /15, weight was 119.9, on a 9.2 pound gain. There was a weights were rechecked anot been notified of the			n Policy updated ocedure staff mission ring sician dded to will be tered e will re and ian ee) will ge in ed as r the dof the of the ill be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			<u>O. 0938-039</u> ATE SURVEY OMPLETED	<u>91</u>
	NAME OF		245612	B. WING				0.10.0.10.0.1.7	
		PROVIDER OR SUPPLIER			100	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST STREET PO BOX 724 IHL, MN 55713		6/02/2015	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DRE	COMPLETION DATE	
	in to record or control or contro	483.13(c)(1)(ii)-(iii), INVESTIGATE/REP ALLEGATIONS/IND The facility must not been found guilty of mistreating residents had a finding entered registry concerning a of residents or misar and report any know court of law against a indicate unfitness for other facility staff to the or licensing authorities. The facility must ensinvolving mistreatment including injuries of unisappropriation of remmediately to the action other officials in action other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also other officials in action of the facility must have also ot	(c)(2) - (4) ORT IVIDUALS employ individuals who have abusing, neglecting, or so by a court of law; or have dinto the State nurse aide abuse, neglect, mistreatment oppropriation of their property; ledge it has of actions by a can employee, which would a service as a nurse aide or the State nurse aide registry es. ure that all alleged violations ont, neglect, or abuse, nknown source and esident property are reported liministrator of the facility and cordance with State law procedures (including to the iffication agency). The evidence that all alleged hely investigated, and must ital abuse while the gress.	F 2		CROSS-REFERENCED TO THE APPROI	'RIATE		
₹	M CMS-2567/	02-99) Previous Versions Obs	- Inde				1		

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

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII TI	DIE COMPTANT	OMB NO	D. 0938-0391
·······································	O CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	245612	B. WING _			
				STREET ADDRESS, CITY, STATE, ZIP CODE	06	/02/2015
CORNE	RSTONE VILLA			1000 FOREST STREET PO BOX 724		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		BUHL, MN 55713		
PRÉFIX TAG	LACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UDDE	(X5) COMPLETION DATE
in the Confidence of the Confi	Based on interview facility failed to ensure reported to the state investigated for 1 of for elopement. Findings include: R44's Admission Recincluded dementia whand depressive type Minimum Data Set (Nosevere cognitive impano mood or behavior dentified R44 require staff for locomotion or dressing, personal hyand transfers. R44's conterventions for elopement and R44 door elopement. No furt issessments were countered, and R44 door elopement. No furt issessments were countered.	and document review, the re a resident elopement was agency (SA) and thoroughly 1 residents (R44) reviewed cord identified diagnoses that ith behavioral disturbance psychosis. The quarterly MDS) indicated R44 had airment, and delusions, but problems. The MDS also id extensive assistance with and off the unit, and for giene, bed mobility, toileting care plan lacked ement until 5/28/15, during ent Risk Assessment was lid not display risk factors her Elopement Risk mpleted. Is identified the following: R44 was attempting to said he was going home to Wanderguard alarm (a R44 was attempting the		DEFICIENCY)	eported County stigation n new ement at risk ard ident on ered ting of the TAR sting dated to Other nent dents ave an d	DATE
by	ogress note indicated	44 was found outside. A d R44 was found outside vay. Staff reported she had		been notified of the risk and the placare. Changes to Prevent Recurrence:	n of	

Facility ID: 23242

STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	TIPLE	OMB N	IO. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
NAMEO	E DDOVIDED OF	245612	B. WING			
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	06/02/2015
CORNI	ERSTONE VILLA			1000 FOREST STREET PO BOX 72	24	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		BUHL, MN 55713		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N CHOILD DE	(X5) COMPLETION DATE
F 226	seen R44 outside ear pushing him. Staff la brought R44 in. The was pushing him was as only helping R4. Wheelchair, and the not to be outside alo minute checks, and at the outside door. On 5/29/15, at 8:20 a service (SS)-A stated been investigated, ar reported to the SA. On 5/29/15, at 9:12 a (DON) stated R44's Wastaff he was outside, new Wanderguard wastated all Wanderguard wastated all Wanderguard wastated all Wanderguard however R44's Wand checked since it was The DON verified the thoroughly investigated the SA. The facility policy and dated 12/08, directed report all cases of mis Abuse Prohibition policy have been reported to the push of the policy and dated the sale of the thoroughly investigated the SA.	arlier with a visitor who was after noticed him alone and person who she had thought as here visiting someone else, 4 navigate a curb in his visitor was unaware R44 was ne. R44 was placed on 10 a stop sign was placed on a stop sign was not sign and a stop sign was not functioning, and a stop sign are to be sure they are functioning, arguard had not been placed on him on 3/18/15. Incident had not been placed on the stop sign and was not reported to a procedure on Elopements staff to investigate and sing residents. The facility cy and procedure dated vestigate all incidents after ed, and this information will the appropriateness of	F 226		edure were /2/2015. Staff in (need to ator, Social in of Nursing) is on proper The revised I the Abuse taff as well as esentatives in/policies by I will review al inistreatment, injuries of propriation of ensure that ely reported investigated. Inicident ine if all incedures ele Abuse dure. These hird quarter ele committee ele audit and continued,	
I CMS 256						

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTI	DI F CONOTTILI	<u>OMB N</u>	<u>0. 0938-039</u>
LAN	OF GORREGION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	245612	B. WING _			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	RSTONE VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713	_ 06	6/02/2015
(X4) ID PREFIX TAG	(LACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D DE	(X5) COMPLETION DATE
F 226	The facility must de policies and proced mistreatment, negle and misappropriation. This REQUIREMEN	velop and implement written	F 226			
	Based on interview facility failed to ensu were developed to reelopement to the sta	and document review, the re policies and procedures eport alleged incidents of te agency (SA) and fe for 1 of 1 residents (DA4)		Cornerstone Villa strives to ensure policy and procedures are up to da are being properly carried out. Corrective Action: The facility Abuse Prevention policy procedure dated 4/08 was reviewed updated on 6/1/2015. The elopement	and and	
Firm an M	this information will be appropriateness of research R44's Admission Reconcluded dementia with depressive type public and depressive type public and the properties of the properties and the properties are the properties ar	directed staff to investigate y have been reported, and e used to determine the eporting to the SA. ord identified diagnoses that th behavioral disturbance psychosis. The quarterly IDS) indicated R44 had airment, and delusions, but problems. The MDS class		updated on 6/1/2015. This update included first reporting is the proper agencies and county common entry and "then" investigating the incident Abuse Prevention Policy also includ requirement that the Administrator (Designee) be immediately notified of alleged incident or injury as well as the Physician, and family member/representative.	state point. The ed the or the che	
st di ar in th	taff for locomotion or ressing, personal hygnd transfers. R44's cape terventions for elope se survey. n 2/5/15, an Elopemompleted, and R44 dispersions.	d extensive assistance with and off the unit, and for		Corrective Action As It Pertains To C Residents: The revised Abuse Prevention policy procedure as well as the revised elopement policy and procedure wer presented to all staff at the 6/17/2018 inservice. This revised abuse preven policy and procedure will be given/mato to each resident and/or family/representative by 6/30/2015.	e 5 tion ailed	

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILI	TIDLE	OMB NO	<u>. 0938-03</u>
"AD I- DAIN	OF GURRECTION	IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION DING	(X3) DA	E SURVEY IPLETED
NAME OF	DD 0.	245612	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	02/2015
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		BUHL, MN 55713		
PRÉFIX TAG	(CACH DEFICIENC)	M MUENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
i si	for elopement. No f Assessments were R44's Incident Report 3/18/15, at 11:35 p.r. leave the facility, and Hibbing. At that time system to alert staff leave out the door) v 5/3/15, at 10:30 a.m. progress note indicate by the end of the driv seen R44 outside ear pushing him. Staff late brought R44 in. The was pushing him was was only helping R44 wheelchair, and the v not to be outside alor ninute checks, and a he outside door. 20 5/29/15, at 8:20 a ervice (SS)-A stated	completed. Dorts identified the following: m. R44 was attempting to desaid he was going home to ea Wanderguard alarm (a if R44 was attempting to was placed on him. R44 was found outside. A sted R44 was found outside yeway. Staff reported she had rilier with a visitor who was ter noticed him alone and person who she had thought is here visiting someone else, a navigate a curb in his visitor was unaware R44 was ne. R44 was placed on 10 in stop sign was placed on 10 in the director of social R44's elegament had a stop sign was placed.	F 2	were also provided with the for abuse under F225" de trees to assist them in descripportable and who to reportable and who to report exists a few staff, residents, arrepresentatives will be prorevised Abuse Prevention procedure. Monitoring: The Social Services Direct incidents to determine if the properly reported and inverse Administrator will audit 5 in week to determine if allegated were reported per the policiprocedure and all were the investigated. These audits until the third quarter QA metime the committee will revioutcome of the audits and caudits will be continued, reconsidered.	termining what is termined with the policy and tor will review all ey were stigated. The termine if the policy and toughly will continue teeting at which iew the determine if the policy and toughly will continue teeting at which iew the determine if the policy and toughly will continue teeting at which iew the determine if the policy and toughly will continue teeting at which iew the determine if the policy and toughly which is the policy and the polic	
re	eported to the SA.	u the incident was not		Completion Date: 6/30/2015		
st ne st ch hc ch	raff he was outside, it was outside, it was outside, it was early wanderguard was ated all Wanderguar necked nightly to ensowever R44's Wanderecked since it was proeced the iterations.	m. the director of nursing and a systems are to be ure they are functioning, and a straight and not been blaced on him on 3/18/15. Incident had not been drawn and was not reported to				

	STATEMEN	T OF DEFICIENCIES		[(YO) 14445		OMB N	O. 0938-039	3 1
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY OMPLETED	
	NAME OF CORNEF (X4) ID PREFIX TAG F 226 F 282 SS=D	PROVIDER OR SUPPLIER RSTONE VILLA SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS) Continued From page the SA. 483.20(k)(3)(ii) SER PERSONS/PER CA The services provided must be provided by accordance with each care. This REQUIREMENT by: Based on document facility failed to monit regarding weight charped for a full of a full residually sis. Findings include: R41's admission minital assessment dated 3/2 diagnoses included eneart failure, and recement anagement of renal Renal care plan dated.	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) The second of the second	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION JLD BE OPRIATE The that all red and y to the ye in a sen sted to scussion nily. The transfer of the description of the de	OMPLETED 6/02/2015 COMPLETION DATE 7/10/15	
	F n o d	diagnoses included enter failure, and recent failure, and dated failuiter fluid restriction from Monday, Wednesd failysis. The care plar hysican was to be not failured failure	2/15 indicated the resident's nd stage renal disease and eived dialysis for failure. 3/31/15 were for 1500 n daily and to be weighed lay and Friday before a also indicated the officed for a weight gain.		Resident R41's weights were take through 6/17/2015. Resident elector stop dialysis on 6/15/2015 after diwith the primary physician and fan Resident elected to receive comfor (hospice services were offered and declined). Resident died on 6/18/2 Corrective Action As It Pertains To Residents: All current residents will be review.	eted to scussion nily. ort care d 2015.		
-	T 3, R 4/	he resident's weight /1/15 to 6/1/15. Ther 41 was weighed on t	record was reviewed from e was no evidence that he following dialysis days: 3, 5/20, 5/22, 5/25 and		specific physician ordered and/or or planned monitoring. This monitoring be entered onto the TAR as well as the resident daily care sheets (weight Licensed Nursing staff will review the resident record/care sheet to ensurinformation is recorded and to review information for change in condition	ng will s onto ghts). he re the		
4	VI CIMIC OFOTA	00.00\ = .				1		

	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/OURRINGS	T		O	MB N	O. 0938-039
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPL ING _	E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
			245612	B. WING				
	NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS CITY OF	0	6/02/2015
	CORNE	RSTONE VILLA			10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 FOREST STREET PO BOX 724		
ŀ						UHL, MN 55713		
ı	(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
	TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE	(X5) COMPLETION DATE
	F 282	aminout Form pag		F 28	82	Ohongoo wa W		
		weight was 117.3, or pound gain. The 3/2 3/4/15, it was 129.1, no documentation than the physician has weight gain on the absolute at 8:50 a.m. indicated before dialysis on Mo Friday. She was una weights in R41's recothe weight variance results.	red nurse (RN)-A on 6/2/15 If the resident was weighed inday, Wednesday and ble to located the missing rd. She further indicated may be discrepancies with on the wheelchair and the		th respectively.	changes, per the physician orders a plan of care, are noted the physician family/representative will be promptly notified. This was completed on ??' Changes To Prevent Recurrence: Notification of change in condition per and procedure was reviewed and up on 6/16/2015. All nursing staff were inserviced on 6/17/2015 on the policiprocedure as well as on the need to the resident plan of care as it pertain monitoring weights, vitals, etc. Physical ordered monitoring will be added to the daily care sheets and will be entered the resident TAR upon receipt of the order weight schedule will be added to the daily care sheets and will be entered the resident record. Licensed Nurse review the weights/information and we notify the physician of changes per the physicians order and residents' plan of care. Monitoring: The Director of Nursing (or Designee and to the physician and analyzeported to the physician and analyzeported to the physician and amily/representative. These audits we ontinue until the third quarter QA me to which time the committee will review the outcome of the audits and determine outcome of the audits and determine outcome of the audits and determined to the physician and determine outcome of the audits and determined to the physician and determined the committee will review the outcome of the audits and determined to the physician and the physician a	n and ly ???. olicy odated follow is to ician he er. CNA will rill et ind will etting w ine if	
					C	ne audits will be continued, reduced, iscontinued. ompletion Date: 12/2015.	or	
_					1		1	i

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	LTIDLE		OMB NO	O. 0938-039	1
AND FLAIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING_	CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED	
NAME OF	PROVIDER OR SUPPLIER	245612	B. WING			0.6	6/02/2015	
	RSTONE VILLA			100	REET ADDRESS, CITY, STATE, ZIP CODE DO FOREST STREET PO BOX 724 JHL, MN 55713)	5/02/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE	
F 309 F 309 SS=D	483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessal or maintain the higher mental, and psychos	ARE/SERVICES FOR EING receive and the facility must ry care and services to attain est practicable physical	F 3	1			7/10/15	
I I a control of the	Based on document facility failed to provide services for a dialysis accurate weights prior abnormal weights to the residents (R41) review Findings include: R41's admission minital assessment dated 3/2 diagnoses included enter failure, and recent failure plant dated failure care plant failure care plant failure care plant failure care plant to dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on Morriday and indicated the services for a dialysis on the services for a dialysis	mum data set (MDS) 2/15 indicated the resident's nd stage renal disease and ived dialysis for failure. 3/31/15 were for 1500 n daily and to be weighed ay and Friday before also indicated the tified for a weight gain		th so idd ywi co 6/	Cornerstone Villa strives to ensure esident receive the monitoring and versight necessary to attain and/onaintain the highest practicable phaental, and psychosocial well-being orrective Action: esident R41's weights were taken rough 6/17/2015 per her dialysis chedule - no abnormal weights we entified. Resident stopped dialysis in e 15th and elected, after discuss the Physician and family to receive omfort cares. Resident R41 died and 18/2015. Perfective Action As It Pertains to Casidents: here are currently no resident received allysis services. All residents have viewed for changes in condition quiring physician, resident and/or nilly/representative notification to have been notified. This was appleted on 6/25/2015.	d or hysical, ag.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY
		245612	B. WING		06/0	2/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1000 FOREST STREET PO BOX 72 BUHL, MN 55713	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	restriction of 1500 symptoms were to the physician: ede pounds a day, incomplete blood pressure. The resident's wei 3/1/15 to 6/1/15. Weights were comphysician ordered 5/1, 5/20, 5/22, 5/2 R41's 4/17/15, we was 127.2, a 2.6 gweight was 117.3, pound gain. The 3/4/15, it was 129 no documentation and the physician weight gain on the Interview with regat 8:50 a.m. indicates of edialysis on Friday. She was weights in R41's resident should have the physician weight gain on the second process of the weight variants and the physician weight gain on the second process of the weight should have been supported to the physician weight gain on the second process of the weight should have been supported to the physician weight should have been supported to the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician weight gain on the second process of the physician process of th	milliliters daily. The following be monitored and reported to ma, weight gain of over 2 reased heart rate and elevated light record was reviewed from There was no evidence R41's epleted on the following dates: 4/3, 4/6, 4/8, 4/15, 4/29, 25 and 5/27/15. Light was 124.6, on 4/20/15, it pound gain. R41's 3/27/15, on 3/3015, it was 129.5, a 12.2 3/2/15, weight was 119.9, on .1, a 9.2 pound gain. There was a the weights were rechecked had not been notified of the	F3	Changes To Prevent Recu The Policy and Procedure Need for Residents on Dia reviewed and communicat staff on 6/17/2015. All res dialysis services will have a developed that is individua resident's needs and phys Residents requiring increa monitoring (any other indiv monitoring) will have this n added to their TAR as well for reporting abnormal wei physician. The schedule i will be obtained will be add resident daily CNA care sh obtaining the weights will we the care sheet and will ent residents' record. A licens monitor the information an physician and family/repre abnormal losses/gains per plan of care and physician Monitoring: The Director of Nursing (of audit 5 residents weekly (a receiving dialysis services condition (including abnor determine if the resident p being followed and to dete physician, resident and/or family/representative have any changes in condition weights. These audits will the third quarter QA meet the committee will review the audits and determine	for Care Plan lysis was ed to nursing idents receiving a care plan lized per each ician orders. sed weight ridualized nonitoring as directions ghts to the n which weights led to the neets. The staff write them on the red nurse will ad report to the sentative all resident orders. The Designee) will all residents orders. The staff write them on the red nurse will are norders. The staff write them into the sentative all report to the sentative all remains orders. The Designee will all residents orders. The Designee will all residents orders. The Designee of the electron of care is the electron of care is the electron of care is the electron of	f

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (2	X3) DATE COMP	SURVEY LETED
		245612	B. WING			06/0	2/2015
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 000 FOREST STREET PO BOX 724 UHL, MN 55713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pa	age 12	F	309	be continued, reduced, or discontinu	ued.	
F 323 SS=D	The facility must er environment remains is possible; and		F	323	7/10/2015		7/10/15
	by: Based on interview facility failed to ensith the facility failed the failed t	NT is not met as evidenced w and document review, the sure a resident elopement was lated for 1 of 1 residents (R44) ment. Record identified diagnoses that with behavioral disturbance be psychosis. The quarterly to (MDS) indicated R44 had inpairment, and delusions, but ior problems. The MDS also uired extensive assistance with in on and off the unit, and for I hygiene, bed mobility, toileting it's care plan lacked lopement until 5/28/15, during			Cornerstone Villa strives to ensure residents remain free of accident has is possible and each resident recadequate supervision and assistant devices to prevent accidents. Corrective Action: Resident R44's elopement was reported to the SA (OHFC) as well as the St County Common Entry Point. A full investigation of the incident was completed with the findings reported the SA and family. An elopement risussessment was completed on 6/2/Care plan was updated, daily alarm testing was added to residents TAR Corrective Action As It Pertains to C Residents: All residents have a current elopement.	orted Louis I d to sk /2015.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		245612	B. WING			06/0	2/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				10	000 FOREST STREET PO BOX 724		
CORNER	STONE VILLA			В	UHL, MN 55713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	completed, and Refor elopement. No Assessments wer R44's Incident Re 3/18/15, at 11:35 pleave the facility, a Hibbing. At that tir system to alert staleave out the door 5/3/15, at 10:30 a progress note ind by the end of the seen R44 outside pushing him. Staf brought R44 in. Twas pushing him was only helping wheelchair, and the outside door. On 5/29/15, at 8:2 service (SS)-A stabeen investigated.	perment Risk Assessment was 44 did not display risk factors further Elopement Risk e completed. ports identified the following: po		323	risk assessment completed. Staff inserviced on 6/17/2015 with the r Abuse Prevention Plan policy and procedure as well as the revised elopement policy and procedure. revised policies and procedures ir information pertaining specifically elopement reporting to the Admin (or designee), SA, St. Louis Coun Common Entry Point, Family/Representative, and the P as well as the requirement for the completion of a thorough investig and the reporting of the results to Administrator, Family/Representat Physician and SA. Included in the and Procedure is the Federal LTR Reportability Under F225 decision trees. Current resident and/or family/representatives will be give revised Abuse Prevention Policy and Procedure by 6/30/2015. Changes To Prevent Recurrence The Abuse Prevention Plan as we Elopement Policy and Procedure reviewed and updated on 6/2/201 includes direction for initial report investigation, and reporting of resnew staff, residents, and Family/Representatives will be given the staff, residents, and	These included to istrator ity hysician ation the ative, e Policy C in making en the and it ell as the were 15 which ing, sults. All	
	(DON) stated R4- staff he was outs new Wanderguar stated all Wande checked nightly to however R44's Wandersheet R44's Wandersheet Since it	4's Wanderguard did not alert ide, it was not functioning, and a d was placed on him. The DON rguard systems are to be o ensure they are functioning, landerguard had not been was placed on him on 3/18/15. If the incident had not been			revised Policy and Procedures. Monitoring: The Social Services Director will alleged violations involving mistre neglect, or abuse, including injuriunknown source and misappropriproperty, and elopements to ens	review all eatment, ies of riation of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245612	B. WING			06/0	2/2015
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 UHL, MN 55713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	thoroughly investigathe SA. The facility policy a	ated, and was not reported to and procedure on Elopements ed staff to investigate and	F3	223	these were properly and timely rep and that they are thoroughly invest The Administrator will audit 5 incid reports per week to determine if al reporting and investigation proced have been carried out per the Abust Prevention Policy and Procedure. audits will continue until the third quality will review the outcomes of the auditermine if the audits will be contreduced, or discontinued. Completion Date: July 10, 2015	igated. ent lures se These uarter mittee dits and	

F5612011

Printed: 05/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 1

(X3) DATE SURVEY COMPLETED

245612

B. WING

05/27/2015

NAME OF PROVIDER OR SUPPLIER

CORNERSTONE VILLA

STREET ADDRESS, CITY, STATE, ZIP CODE

1000 FOREST STREET PO BOX 724

		BUHL	MN 55713		
(X4) ID PREFIX (TAG	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL F 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:
K 000	INITIAL COMMENTS		K 000		-
- which are the second to the control	FIRE SAFETY				
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety. time of this survey, Cornerstone Villa, we in substantial compliance with the require for participation in Medicare/Medicaid at Subpart 483.70(a), Life Safety from Fire 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Scode (LSC), Chapter 18 New Health Care	At the as found rements 42 CFR, and the			
	Cornerstone Villa is a one story building basement. It was constructed in 2004/20 construction type was determined to be (111).	005. The			
	The building is fully sprinkler protected. facility has a complete automatic sprinkl system, with smoke detection in the correspaces open to the corridor, that is mon automatic fire department notification. A resident rooms have single station smokedetectors that transmit to the nurses state facility has a licensed capacity of 44 bed census was 42 at the time of inspection.	er ridors and itored for All ke tion. The ls, the		>	
	It is the determination of this Life Safety Surveyor that the fire sprinkler coverage resident rooms is adequate to provide of unobstructed coverage to the exterior of wardrobe closets in accordance with NF (99) and CMS S & C-05-38, A1.	in the omplete the			
	The requirement at 42 CFR Subpart 483 met.	3.70(a) is	to fine state of the state of t		Compression of the American Control of the Control

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.