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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4R9M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00974

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245307**

2.STATE VENDOR OR MEDICAID NO.
(L2) **458430000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE NSG & REHAB CENTER**
(L4) **416 SEVENTH STREET NORTHEAST**
(L5) **BAGLEY, MN** (L6) **56621**

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) **01/01/2008**

6. DATE OF SURVEY **07/13/2015** (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)
09/30

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
Jana Bromshenkel, HFE NEII 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/14/2015 (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
03/01/1986 (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
06/17/2015 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245307

September 14, 2015

Ms. Kari Swanson, Administrator
Cornerstone Nursing & Rehabilitation Center
416 Seventh Street Northeast
Bagley, Minnesota 56621

Dear Ms. Swanson:

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 June 20, 2015 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 20, 2015

Ms. Kari Swanson, Administrator
Cornerstone Nursing and Rehabilitation Center
416 Seventh Street Northeast
Bagley, Minnesota 56621

RE: Project Number S5307025

Dear Ms. Swanson:

On June 1, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 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 July 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 21, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2015, effective June 20, 2015 and therefore remedies outlined in our letter to you dated June 1, 2015, will not be imposed.

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

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing	7/13/2015

Name of Facility	Street Address, City, State, Zip Code
CORNERSTONE NSG & REHAB CENTER	416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621

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 **F0258** Reg. # **483.15(h)(7)** LSC	Correction Completed **06/11/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/20/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/11/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/20/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	07/20/2015	32601	07/13/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/21/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4R9M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00974

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(L1) **245307**

2.STATE VENDOR OR MEDICAID NO.
(L2) **458430000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE NSG & REHAB CENTER**
(L4) **416 SEVENTH STREET NORTHEAST**
(L5) **BAGLEY, MN** (L6) **56621**

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) **01/01/2008**

6. DATE OF SURVEY **05/21/2015** (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)
09/30

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

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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
	43			
(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 :
Jana Bromenshenkel, HFE NEII — 06/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 06/16/2015 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
03/01/1986
(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
Posted 06/17/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5307

At the time of the May 21, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the standard survey, an investigation of complaint number H5307012 was conducted and found to be unsubstantiated. The most serious deficiency 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 are required. Please refer to the CMS-2567 for both health and life safety code along with the facilitys plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 1, 2015

Ms. Kari Swanson, Administrator
Cornerstone Nursing and Rehabilitation Center
416 Seventh Street Northeast
Bagley, Minnesota 56621

RE: Project Number S5307025, H5307012

Dear Ms. Swanson:

On May 21, 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. In addition, at the time of the standard survey an investigation of complaint number H5307012 was conducted and found to be unsubstantiated.

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;

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 June 30, 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 August 21, 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 November 21, 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

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. An investigation of complaint H5307012 was also completed. The complaint was not substantiated.	F 000		
F 258 SS=C	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable sound levels were provided in 1 of 2 dining areas (main dining room) observed. This had the potential to affect all 28 residents who dined in the main dining area. Findings include:	F 258	Cornerstone Nursing and Rehab Center strives to maintain a comfortable sound level for our residents, staff, and visitors at all times. On May 26, 2015, the Environmental Services Supervisor lined the bottom of the ice machine with Styrofoam and added rubber cushion mounts under the compressor pump to aide in improving the noise. Verbal follow up interviews of residents, visitors, and staff were	6/11/15

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

Electronically Signed | 06/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 1 On 5/18/15, at 5:09 p.m. during the main dining room meal observation, staff were observed to serve the supper meal. Other than mealtime conversation, the room was quiet. - At 5:17 p.m. the ice machine in the dining room started up and made a loud, clanky, humming noise. Both staff and residents were heard to raise their voices in order to speak over the loud noise of the ice machine. - At 5:28 p.m. the ice machine stopped making the noise. - At 5:29 p.m. the ice machine again started to make the same noise. - At 5:35 p.m. the ice machine stopped and restarted making the noise again at 5:37 p.m. - At 5:49 p.m. the ice machine noise stopped. On 5/19/15, at 11:21 a.m. during the main dining room lunch meal, the ice machine was heard running and making the same loud, clanky, humming noise. On 5/20/15 at 11:03 a.m. the lunch meal preparation and setup was observed in process. The ice machine was heard running and making a loud, clanky, humming noise and stopped at 11:24 a.m. -At 11:24 a.m. resident (R)-6 stated the ice machine was always loud. -At 11:25 a.m. the ice machine started making the load humming noise. -At 11:26 a.m. R13 confirmed the ice machine was noisy and stated the noise was very distracting when trying to eat. -At 11:40 a.m. the ice machine stopped. -At 11:42 a.m. the ice machine started to hum	F 258	conducted June 1-8, with little satisfaction of improvement. On 6/8/15 maintenance inspected the ice machine to determine if anything was broken and added more rubber cushion. On 6/9/15, staff confirmed the noise had not significantly improved. On 6/10/15 the decision was made to unplug the ice machine and remove it from service. The ice machine in the second dining room shall be utilized by all residents, staff and visitors as its replacement. The Environmental Services Supervisor shall complete weekly facility inspections for 3 months or until compliance has been reached to ensure all equipment is in proper working order and at comfortable sound levels. Results of these audits shall be reviewed at the facility Quality Assurance meetings.	

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F 258	Continued From page 2 again. On 5/20/15, at 11:45 a.m. the choice therapist confirmed the ice machine was "very loud" when it was on. On 5/20/15 at 11:54 a.m. licensed practical nurse (LPN)-A stated they had gotten used to the noise, but when others came in they would comment about how terrible that noise was. Nursing assistant (NA)-A also confirmed the ice machine was loud. -At 11:58 a.m. dietary aide (DA)-A stated she had not heard of any complaints but stated the noise was "obnoxious" and was usually worse in the morning. On 5/20/15, at 12:15 p.m. the director of nursing (DON) verified the ice machine was noisy and stated it needed to be replaced. A policy and procedure related to noise comfort levels was requested and not provided.	F 258		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		6/20/15

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F 280	Continued From page 3 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include interventions regarding emergency care for 1 of 1 resident (R59) reviewed for dialysis. Findings include: R59's Physician Order Report dated 4/21/15 - 5/21/15, indicated R59 had diagnoses that included chronic stage III kidney disease, diabetes mellitus with renal manifestations and renal dialysis noncompliance. R59's quarterly Minimum Data Set (MDS) dated 4/12/15, indicated R59 was cognitively intact and was independent for activities of daily living. The MDS also indicated R59 received dialysis treatment.	F 280	Cornerstone Nursing and Rehab Center strives to have the residents participate in planning care and treatment or changes in care and treatment. Care plans will be prepared by an interdisciplinary team, completed within 7 days after the comprehensive assessment is done, and periodically reviewed. R59¿s care plan was reviewed and updated on 6/8/15 with added interventions related to the monitoring and care of R59¿s arteriovenous (AV) fistula and including emergency management of the AV fistula. Care plan also updated in collaboration with the Devita Dialysis unit, with phone numbers accessible in the chart. Daily assessment of the AV fistula was added to the electronic medical administration record (EMAR) for each shift to continue to monitor the site for bleeding, pain, swelling, and signs of infection. Any and all residents receiving Dialysis	

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F 280	Continued From page 4 R59's care plan identified R59 received dialysis every Monday, Wednesday and Friday, however lacked interventions related to the monitoring and care of R59's arteriovenous (AV) fistula (a type of access made by joining an artery and a vein under the skin in the arm used to access the blood for hemodialysis treatment). The care plan also lacked interventions regarding treatment in the event of an emergency. On 5/21/15, at 1:37 p.m. the dialysis unit's registered nurse (RN)-B stated she would expect the facility to monitor R59 for bleeding, pain, swelling and signs of infection in the arm with the AV fistula and to avoid using the arm for blood pressures and blood draws. On 05/21/2015, at 2:34:14 PM the director of nursing (DON) verified R59's care plan lacked interventions regarding emergency procedures and AV fistula care and confirmed they should have been included on the care plan. The undated Care of the Dialysis Patient policy directed staff to assure resident's fistula does not hemorrhage by: Assess fistula site daily and observed for signs and symptoms of bleeding from the site/bruising/swelling. Assess for signs and symptoms of infections. Palpate fistula site for thrill and listen with a stethoscope over site for bruit. If bleeding occurred at the fistula site: apply firm pressure to the site for at least 10 minutes and then reevaluate. If bleeding stopped but recurred after pressure was relieved contact the dialysis unit or ER. If unable to control the bleeding with direct pressure contact the ER	F 280	shall have their care plan include interventions regarding emergency care. Appropriate nursing staff were educated with updates at a mandatory in-service on 6/2/15, which included review of the policy and procedures of caring for a hemodialysis resident. Staff educated to review the updated care plan by 6/19/15. The Director of Nursing or designee shall complete monthly random audits and quarterly for 6 months to ensure compliance continues to be met or until compliance is reached. Results of these audits shall be reported at the facility Quality Assurance meetings.	

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F 280	Continued From page 5 immediately. No blood pressures or blood draws or tight clothing on extremity with the fistula.	F 280		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		6/11/15

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F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper narcotic storage and security for 1 of 2 medication carts (100/300 wing cart) was maintained. Findings include: On 5/21/15, at 1:00 p.m. the 100/300 wing medication cart was observed to be locked, however the narcotic drawer in the cart which had a key lock on the top of the drawer was unlocked. Reconciliation of the drawer's content revealed 20 Tylenol with codeine tablets. At this time, the director of nursing (DON) confirmed the observations and stated it should have been locked. The Controlled Substances policy dated 2/8/13, specified narcotic medications would be stored in a locked box within the locked medication cart and the locked box containing the narcotics must remain locked at all times.	F 431	Cornerstone Nursing and Rehab Center strives to store all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. We strive to maintain and ensure proper narcotic storage and security while in the medication carts. Facility policies have been reviewed and updated as necessary. Individual staff has been educated along with all nursing staff attending a mandatory in-service on 6/2/15 to educate on current policies. All resident narcotics shall be properly stored in a locked box in the locked medication cart. The Director of Nursing or designee shall complete weekly random audits of medication carts for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility Quality Assurance meetings.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		6/20/15

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F 441	Continued From page 7 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was performed for 1 of 2 residents (R50) observed during wound care. Findings include:	F 441	Cornerstone Nursing and Rehab Center strives to continuously institute and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection to	

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F 441	Continued From page 8 R50's Resident Admission Record dated 4/24/15, indicated R50 had diagnoses that included paraplegia, pressure ulcer and osteomyelitis. R50's admission Minimum Data Set (MDS) dated 5/1/15, indicated R50 had one unhealed stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), two unhealed stage III pressure ulcers (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling), one unstagable pressure ulcer with suspected deep tissue injury in evolution and was at risk for the development of further pressure ulcers. On 5/20/15, at 10:36 a.m. licensed practical nurse (LPN)-B was observed to wash her hands, enter R50's room, gather supplies from the bathroom and place them by R50's bedside. LPN-B proceeded to double glove her hands and remove the old wound dressings and packing material from R50's right hip, right ischial and coccyx wounds. LPN-B discarded the soiled dressings and changed her gloves without performing hand hygiene. Using a sterile swab, LPN-B packed R50's right hip wound with 2 inch conform (stretch gauze) dressing soaked in Dakin's solution (antiseptic solution containing sodium hypochlorite and developed to treat infected wounds), covered the wound with an ABD bandage (a broad multilayered absorbent gauze), removed and discarded her gloves and taped the	F 441	its residents, employees, and visitors. Facility policies have been reviewed and updated as necessary. Individual staff has been educated along with all nursing staff attending a mandatory in-service on 6/2/15 to educate on updated and current policies. Tracking and trending of hand hygiene during dressing changes has been initiated. Wound care for R50 shall be demonstrated by LPN-B to the Director of Nursing or designee to ensure proper infection control procedures are followed. All residents receiving wound care shall receive proper treatment to prevent the spread of infection. The Director of Nursing or designee shall complete weekly random audits of employee hand washing and glove use during dressing changes for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility Quality Assurance meetings.	

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F 441	Continued From page 9	F 441		

dressing into place. LPN-B proceeded to write the current date on the new dressing. LPN-B went to the bathroom and attempted to wash her hands. The soap dispenser did not dispense soap. LPN-B rinsed her hands in water and dried with paper towels. She did not utilize hand sanitizer. LPN-B donned clean gloves and applied a Mepilex dressing (self-adherent absorbent foam) to the coccyx wound, discarded her gloves and wrote the current date on the new dressing. LPN-B donned clean gloves, without first performing hand hygiene. Utilizing a sterile swab, LPN-B then packed the right ischial wound with plain packing strips (long thin strips of woven gauze) soaked in Dakin's solution, cut off the excess packing strips with a scissor and covered the wound with a 4 x 4 inch gauze pad folded into fourths and taped it into place. LPN-B removed and discarded her gloves and documented the current date on the new dressing. LPN-B asked R50 to reposition on his other side which he then did independently. LPN-B donned clean gloves without first performing hand hygiene and removed the old dressing and packing material from R50's left ischial wound and discarded them into the garbage. LPN-B removed and discarded her gloves and attempted to wash her hands in the bathroom. The soap dispenser did not dispense soap. LPN-B rinsed her hands in water and dried with paper towels. She did not utilize hand sanitizer. LPN-B donned clean gloves and utilizing a sterile swab, packed the left ischial wound with 2 inch conform soaked in Dakin's solution. LPN-B covered the left ischial wound with an ABD dressing and taped it into place. She then removed her gloves, dated the new dressing, bagged the garbage and exited the room. LPN-B washed her hands in the restroom next to the nurses' station.

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F 441	Continued From page 10 On 5/20/15, at 11:05 a.m. LPN-B confirmed the soap dispenser in the bathroom had not dispense soap therefore was unable to wash her hands properly. LPN-B also verified she had not utilized hand sanitizer with her gloves changes and should have done so. On 5/20/2015, at 1:50 p.m. the director of nursing (DON) confirmed she would expect hand hygiene to be performed between the removal of dirty dressings and the application of clean dressings as well as between care of different wounds. The DON also confirmed the soap dispenser in R50's bathroom had been out of order but had since been repaired. The undated Dressings, Dry/Clean procedure directed staff to wash and dry hands thoroughly and apply clean gloves between removing the dirty dressing and applying the clean dressing. However, the policy did not address hand hygiene when changing dressings on multiple wounds.	F 441		

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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 Nursing and Rehab Center 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 19 Existing Health Care. The facility was inspected as two separate buildings: The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection is in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have battery operated smoke detectors installed. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code (2007 edition). The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a	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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1 census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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F5307023

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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02** B. WING _____	**05/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NSG & REHAB CENTER	**416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		