DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 14, 2023

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

RE: CCN: 245307
Cycle Start Date: September 20, 2023

Dear Administrator:

On November 7, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2023

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

Re: Reinspection Results
Event ID: 6DTP12

Dear Administrator:

On November 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2023

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

RE: CCN: 245307
Cycle Start Date: September 20, 2023

Dear Administrator:

On September 20, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 20, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 09/20/2023

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
E 000	Initial Comments On 9/18/23 through 9/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/18/23 through 9/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint(s) were reviewed: H53075593C (MN95998) with no deficiency ; and H53075592C (MN91452) with a deficiency issued at F626. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/3/23

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform the physician of a medication error for 1 of 5 residents (R32)reviewed unnecessary medications. Findings include: R32's annual Minimum Data Set (MDS) dated 7/24/23, included a diagnosis of hypertension. R32's physician order dated 8/17/22, identified R32 was to receive amlodipine (a blood pressure medication) 5 miligrams (mg) by mouth every day. R32's Medication Administration History dated 9/1/23 through 9/20/23, identified the following: - On 9/1/23, R32 was not administered amlodipine due to "medication was not there, pharmacy called". - On 9/2/23, R32 was not administered amlodipine due to "unavailable". - On 9/3/23, R32 was not administered amlodipine due to "unavailable". - On 9/4/23, R32 was not administered amlodipine due to "unavailable". - On 9/5/23, R32 was not administered	F 580	Cornerstone Nursing and Rehab Center strives to provide timely notification to the resident, physician and resident representative when there is a change in medication administration, including medication errors. R32's amlodipine medication was obtained from pharmacy and administered upon receipt of medication as per order. The physician was notified of R32 medication error. An audit has been completed on all residents by reviewing the facility EMR compliance report for the past 30 days to ensure no other residents have been affected. The facility Medication Error Reporting policy and form have been updated and Licensed nursing staff have been educated on 10/10/23. Education included change of condition notification and the updated medication error reporting policy and form. A post-test was given to ensure understanding and competency. Licensed nursing staff not in attendance shall be educated with post-test prior to next scheduled shift. The Director of Nursing or designee shall audit administration compliance reports	

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F 580	Continued From page 3 amlodipine due to "unavailable". - On 9/6/23, R32 was not administered amlodipine due to "unavailable". - On 9/7/23, R32 was not administered amlodipine due to "unavailable". - On 9/8/23, R32 was not administered amlodipine due to "unavailable". - On 9/9/23, R32 was not administered amlodipine due to "unavailable". - On 9/10/23, R32's amlodipine was administered - On 9/11/23,R32 was not administered amlodipine due to "unavailable". R32's nursing progress note dated 9/11/23 at 10:49 a.m., identified R32's amlodipine medication card was missing since 9/10/23. The pharmacy was called and the pharmacy would deliver the medication that evening. The note failed to identify if R32's physician was notified of the repeated medication errors. During an interview on 9/20/23 at 10:05 a.m., licensed practical nurse (LPN)-A stated when a medication was missing, she would first check the rest of the cart to ensure it was not placed in the wrong area, then check the medicaiton room to make sure it wasn't missed after a pharmacy delivery. If the medication still could not be found, LPN-A would call the pharmacy to ask that it be delivered. If the pharmacy could not deliver the medication or if there was a medication error, the physician would be notified to determine next steps. Physician notification was important because, ultimately, the physician had say over all medications and it could affect a resident's care. For example a resident missing a dose of vitamin may not be a big deal, but missing a blood pressure medication could lead to a stroke. LPN-A did not administer R32's medication	F 580	three times a week for four weeks, then weekly for two weeks, and randomly thereafter. Results shall be reviewed at QAPI to ensure compliance and determine if additional monitoring is necessary.	

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F 580	Continued From page 4 because the medication was missing and could not recall if she had contacted the pharmacy nor R32's physician. During an interview on 9/20/23 at 10:37 a.m., the director of nursing (DON) stated she would expect nursing to perform a full resident assessment when a medication error occurred, notify the pharmacy of the needed medication, and to notify the resident's physician to request guidance. In addition, the nursing staff were expected to fill out a medication error form which was submitted to the DON for investigation. The DON stated was unaware of R32's missing amlodipine and was unable to locate a completed medication error form for R32. During a telephone interview on 9/20/23 at 11:15 a.m., pharmacist-A stated the pharmacy received a call from the facility on 9/11/23, requesting R32's amlodipine. The previous cart exchange was delivered on 8/31/23 and would have been used 9/1/23-9/14/23. If a medication was missing, normally, the facility would call as soon as it was found. The pharmacy does ask facility staff to go through all the delivery boxes to ensure it was not missed but would deliver the medication the same day. Amlodipine stopped abruptly could cause an elevated blood pressure that could potentially lead toa higher risk for complications such as stroke. During a telephone interview on 9/20/23 at 2:05 p.m., R32's physician stated he was not informed of R32's medication error. The physician stated he never had this happen before but would expect nursing to contact him in the first 24 hours to inform him R32 did not have medication. The physician would contact the pharmacy to ensure	F 580		

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F 580	Continued From page 5 R32 would receive her scheduled medications. Secondly, the physician would expect nursing to assess R32, especially R32's blood pressure, because not having a medication could lead to an increase in blood pressure and complications could ensue. The facility policy Medication Error Reporting revised 8/24/22, identified the medication error was to be reported immediately when noted to the DON or charge nurse. The DON or charge nuse would take proper action and steps to ensure the safety of the resident and assess need to immediately notify the physician. The person finding the medication error would correct, when able, and fill out the Medication Error Form and file with the DON. Documentation was to be made by the person finding the error in the Medication Error Form. The DON or as designated by the DON shall review with the individual who made the error and provide education and means to prevent further errors.	F 580		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-	F 626		11/3/23

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F 626	Continued From page 6 (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to readmit residents after a hospitalization for 1 of 1 resident (R147) reviewed for discharge. Findings include: R147's discharge Minimum Data Set (MDS) dated 2/20/23, identified R147 was discharged on 2/20/23, with facility return anticipated. R147 had severe cognitive impairment. Diagnosis included chronic obstructive pulmonary disease (COPD) and R147 had shortness of breath or trouble breathing with exertion, at rest and when lying flat.	F 626	Cornerstone Nursing and Rehab Center shall permit residents to return to the facility after hospitalization or therapeutic leave, unless specific exceptions are met. Facility Notice of Bed Hold and Return policy was reviewed with no changes made. This policy addresses permitting residents to return to the facility and readmission to a composite distinct part. R147 expired prior to returning to the facility. An audit has been completed on all current admissions, re-admissions and discharges using the facility admit/discharge report within the last 3 months and was determined no other	

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F 626	Continued From page 7 R147's progress notes identified the following: - 2/20/23 at 5:09 a.m., R147 was transferred to the emergency department (ED) and later that morning was admitted to the hospital. - 2/22/23, R147's son contacted the facility reporting R147 may be ready for discharge and he wanted R147 to return to the facility that same day. R147's son was told by facility staff they would not be able to readmit the resident after 1:00 p.m. due to staff shortage. - 2/24/23 at 12:07 p.m., the facility received an update from the hospital case manager identifying a decline in R147 condition and the plan was to discuss possible comfort cares for the resident. - 2/25/23 through 2/26/23, R147's progress notes failed to identify communication between the facility and hospital regarding discharge planning. R147 hospital notes identified the following: - 2/20/23, R147's emergency department (ED) visit notes identified R147 arrived at the ED at 5:12 a.m. and was admitted to the hospital for further care. - 2/25/23 at 10:00 p.m., the medical center daily progress notes identified R147's family decided to place R147 comfort cares and planned to discharge R147 back to the nursing home for hospice care. R147's progress notes identified the following: - 2/27/23 at 10:08 a.m., the Long-Term Care Ombudsman left a voicemail for the administrator on 2/25/23, and the administrator returned the call and left a voicemail. The hospital wanted to transfer R147 back to the facility on 2/25/23, but the facility had been unable to accept the	F 626	residents were affected. Licensed nursing staff were educated on the Notice of Bed Hold and Return policy and procedures on 10/10/23. Licensed nursing staff not in attendance shall be educated prior to the next scheduled shift. A readmission checklist has been created and reviewed during education. The Director of Nursing or designee shall complete audits on hospital transfers and readmissions weekly for four weeks, one time every two weeks for one month, and randomly thereafter. Results shall be reviewed at QAPI to ensure compliance and determine if additional monitoring is necessary.	

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F 626	Continued From page 8	F 626		

resident. The progress notes failed to identify why R147 was not accepted for transfer.
- 2/27/23 at 11:03, R147's son provided an update to the facility regarding the residents declining health status. R147's family had wanted R147 to return to the facility.

On 9/19/23 at 3:34 p.m., a phone call was attempted to reach the facility ombudsman's and was notified the ombudsman was out of the office until 9/26/23.

During interview on 9/19/23 at 3:12 p.m., the social worker (SW) stated when a resident was transferred out of the facility, the nurses were responsible for obtaining a written or verbal consent for a bed hold indicating the facility would accept the resident back when they were medically stable. Staffing should not affect when a resident is readmitted to the facility. According to R147's progress notes, the hospital case manager called inquiring about readmitting the resident back to the facility but the facility was unable to readmit due to not having a registered nurse (RN) available to re-admit the R147.

During interview on 9/20/23 at 8:38 a.m., the hospital case manager (CM) stated On 2/20/22, R147 was admitted to the hospital for acute care. On 2/22/253, R147's family elected comfort care due to R147's decline in health. On 2/23/23, the hospital talked with R147's son who was trying to coordinate a care conference with the facility to update on residents' health status. On 2/24/23, the hospital case manager talked with the nursing home staff who stated they would be able to provide comfort cares for R147 but they were unable to readmit the resident over the weekend due to no RN coverage. R147's family verbally

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F 626	Continued From page 9 agreed to a bed hold for R147, which meant the facility agreed to and could not refuse to readmit the resident when they were medically stable. CM would expect the facility to readmit even on a weekend. During interview on 9/20/23 at 12:27 p.m., the director of nursing (DON) stated when a resident was transferred to the hospital, the facility would work with the hospital case manager to accommodate the residents needs and plans for readmission, including readmissions on the weekends. The facility was currently only taking readmissions during the work week because that is when the admitting nurses worked. R147 should have been readmitted to the facility and received comfort cares in R147's home. By not readmitting over the weekend R147 was not allowed to die at R147's home where she was comfortable with her family nearby. R147's progress noted lacked evidence of thorough discharge and readmission plans. Due of the lack of documentation in R147's progress notes the DON was unable to determine if the facility provided a good faith effort to readmit R147. The facility Notice of Bed Hold Policy and Return reviewed 10/24/22, identified a resident would be readmitted to the facility to the first available bed if the facility could meet their needs. A readmission policy was requested but not received.	F 626		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		11/3/23

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F 684	Continued From page 10 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide initial wound assessments for 2 of 2 residents (R148, R21); and failed to provide dressing changes as directed for 1 of 2 residents (R21) reviewed for non-pressure related wounds. Findings include: R148's entry Minimum Data Set (MDS) dated 9/13/23, identified R148 admitted to the facility on 9/13/23. R148's undated face sheet identified diagnoses of gangrene (a condition which happens when the blood flow was cut off to an area of tissue. this causes tissues to breakdown and die and often turns affected area to a greenish-black color) of a left tow, osteomyelitis (bone infection). R148's hospital discharge summary dated 9/13/23, identified R148 had chronic left foot osteomyelitis, and a worsening left lower extremity (foot) wound concerning for progression of underlying osteomyelitis and gangrene. Identified wound on foot next to the 5th metatarsal (little toe). Osseous edema (swelling in or of bone) in the 2nd, 3rd, and 4th toes and is concerning for osteomyelitis. R148's progress notes identified the following:	F 684	Cornerstone Nursing and Rehab Center shall ensure wound assessments and quality wound care are provided to our residents. R21's wound was assessed by the Registered Nurse on 9/19/23, notified physician of condition and weekly monitoring was implemented. R148 was discharged on 9/29/23. The facility EMR administration history report was audited for the previous 30 days on all residents to ensure no others were affected. Initial skin assessments shall be completed on all new admissions and a wound assessment on newly identified wounds, by a licensed nurse. Random audits shall be completed on all residents with dressing changes for compliance by reviewing the facility EMR administration history report weekly for 4 weeks, every other week for 4 weeks, than randomly thereafter. Licensed nursing staff were educated on providing proper and timely wound care as well as the need for initial and on-going assessments on 10/10/23. Licensed nursing staff not in attendance shall be educated prior to the next shift worked. The Director of Nursing or designee shall complete audits on wound assessments for current and new admissions weekly for	

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F 684	Continued From page 11 -9/13/23 at 11:56 a.m., R148 was hospitalized for osteomyelitis and gangrene of 4th toe on left foot and required daily dressing changes to left foot. -9/13/23 at 10:03 p.m., R148 was admitted for osteomyelitis and gangrene of left food. Skin addressed dressing change to left foot. -9/14/23 at 1:43 p.m., "Wound? RN notified, wound progress note completed? Right foot, dressings?" -9/15/23 at 1:28 p.m., "Wound? RN notified, wound progress note completed? Left foot, dressings?" -9/16/23 at 12:56 p.m., "Dressings? Left foot/toe dressing, skin color?" -9/17/23 at 11:11 p.m., "Dressings? Left foot dressing to gangrene toes." 9/18/23 at 2:35 p.m. "Wound? RN notified, wound progress note completed? Left foot, dressings?" R148's medical record lacked an initial wound/skin assessment. The initial wound/skin assessment was requested and not received. During an interview on 9/19/23 at 1:51 p.m., registered nurse (RN)-A stated when residents are admitted with wounds or dressing changes, one of the RN managers would do a wound assessment within 20 hours of admit and it would be charted in the progress notes. The importance of the initial wound assessment would be to track any changes to the wound and monitor for improvement. RN-A did not do the initial assessment on the wound. RN-A was not able to find an initial wound assessment in R148's chart and identified it was not completed. On 9/20/23 at 11:00 a.m., RN-B was completed a dressing change for R148. RN-B stated one of the nurse managers would do wound assessment	F 684	four weeks, then every other week for four weeks, and randomly thereafter. Results shall be reviewed at QAPI to ensure compliance and to determine if additional monitoring is necessary.	

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F 684	Continued From page 12 for residents within 24 hours of admit. The reason for the wound assessment was to watch for change and would notify provider if getting worse. RN-B could not find a wound assessment in the chart. RN-B continued with the dressing change. The dressing was removed, and the left foot cleansed. The left foot had a 1.5 centimeter (cm) round concave area next to her little toe, the skin was intact and had no drainage, but was gray in color. The 4th toe was black and was dried up and toenail was ready to fall off. The 3rd toe had some dark areas, and the toenail bed was black. The 2nd toe had some darker areas, but the toenail was intact. During an interview on 9/20/23 at 1:58 p.m., the director of nursing (DON) stated all wounds should be assessed on admit or within 24 hours. The importance of the assessment was to ensure monitoring of the wound and identify any changes that would be happening. If a wound assessment was not documented, she could not verify it was done and staff would not be able to monitor the wound. R21's quarterly Minimum Data Set (MDS) dated 7/11/23, identified severe cognitive impairment. R21 was an extensive assist with personal hygiene. R21's progress note(s) identified the following: - 9/12/23 at 10:43 a.m., the bath aid reported small open area on left lower abdomen. -Mepilex (adsorbent foam dressing) applied. - 9/13/23 at 9:17 p.m., there was an abrasion on left lower abdomen and was cleaned and new dressing applied. - 9/17/23 at 9:24 p.m., the writer went to do the dressing change and identified the dressing in	F 684		

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F 684	Continued From page 13 place was dated 9/14/23, and had not been changed in three days. When the dressing was removed there was thick, purulent drainage on the dressing and increased amount of redness around wound compared to the last time the writer changed the dressing on 9/13/23. R21's medical record lacked an assessment of the wound. The wound assessment was requested and not received. R21's September Medication Administration Record (MAR) identified an order for daily dressing changes was started on 9/12/23. The dressing's were signed of as changed and completed daily 9/12/23 through 9/17/23 An interview with the director of nursing (DON) and registered nurse (RN)-A was conducted on 9/20/23 at 2:04 p.m.. DON and RN-A stated when the wound was identified on 9/13/23, it should have been assessed within 24 hrs and R21's chart lacked a wound assessment for the left lower abdomen. They were both unaware of the progress note on 9/17/23, which identified the dressing on R21's left lower abdomen was not changed for three days, when daily dressing changes were ordered. The DON stated she expected staff to assess, monitor and do timely dressing changes as ordered. A wound/skin assessment policy was requested but none received.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		11/3/23

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F 756	Continued From page 14 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure pharmacy consultants	F 756	Cornerstone Nursing and Rehab Center shall ensure all resident drug regimens	

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F 756	Continued From page 15 recommendations were followed up on in a timely manner for 3 of 5 residents (R29, R32) reviewed for medication management. Finding included: R29's quarterly Minimum Data Set (MDS) dated 8/4/23, identified R29 had moderate cognitive impairment with diagnoses of non-Alzheimer's dementia, and Huntington's disease (a rare, inherited disease that causes the progressive breakdown (degeneration) of nerve cells in the brain). R2 received antianxiety and antidepressant medications. R29's Consulting Pharmacist's Medication Review Physician Recommendation dated 3/23/23, identified R29 received trazodone (an antidepressant and sedative) 50 milligram (mg) tablets. The Centers for Medicare and Medicaid Services (CMS) required evaluation of psychotropic (medications which affect a person's mental state) medications. This was to be addressed as soon as possible but no later than 60 days. R29's medical provider reviewed and signed off on the Consulting Pharmacist Medication Review on 9/20/23. It was over 180 days after recommendation was given and was only addressed after the surveyor requested the information. The provider noted "drug d/c (discontinued) already" and was rejected but did not identify when if it happened. During an interview on 9/20/23 at 1:27 p.m., the director of nursing (DON) stated there as a period of time where the facility did not received any Consultant Pharmacist's Medication Reviews through pharmacy portal and some may have been missed. The facility did not call the	F 756	are reviewed at least once a month by a licensed pharmacist and followed up on in a timely manner. R32 famotidine 20mg was discontinued on 9/20/23 and R29 trazodone 50mg was discontinued on 12/2/22. Additional Registered Nurses have been given access to the pharmacy portal to retrieve drug regimen pharmacy reviews and ensure follow up is completed in a timely manner. Nursing shall perform an audit on all residents who received anti-depressants and PPIs in the last 30 days, by using the order by category report to check for similarities and shall notify the physician of any irregularities. Drug Regimen education and post-test has been completed by Registered Nurses responsible for review and follow through on pharmacy recommendations. The Director of Nursing or designee shall review the monthly pharmacy review summary report for 3 months to audit and ensure all recommendations are addressed in a timely manner. Results shall be reviewed at QAPI to ensure compliance and to determine if additional monitoring is necessary.	

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F 756	Continued From page 16 pharmacy to request the medication reviews. The medication reviews would be expected to be addressed within the stated time periods to ensure residents were not receiving unnecessary medications. The medication review from 3/23/23, was not addressed until 9/20/23, after survey entered.. R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia, hypertension, bipolar disorder and anxiety. R32 utilized antipsychotic, antidepressant and anticoagulant medications. R32's Consulting Pharmacist's Medication Review Recommendation dated 1/18/23, identified R32 received famotidine (a gastric acid secretion reducer) 20 mg tablets. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Mediation Review dated 1/18/23, and noted "pros greater than cons." R32's Consulting Pharmacist's Medication Review Recommendation dated 2/21/23, identified R32 received fluoxetine (an antidepressant) 20 mg capsules. CMS required evaluation of psychotropic medication. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review	F 756		

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F 756	Continued From page 17 on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "patient still depressed, continue." R32's Consulting Pharmacist's Medication Review Recommendation dated 3/28/23, identified R32 received famotidine (a gastric acid secretion reducer) 20 mg tablets and omeprazole (a gastric acid secretion reducer and proton pump inhibitor (PPI)) 20 mg delayed release (DR) capsules . The pharmacist identified R32 continued to take both mediation and acid secretion should be adequately suppressed with the PPI alone. The pharmacist suggested to consider re-assessing the ongoing need for both acid reducers and consider discontinuing one of the medications, if possible. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review dated on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "discontinue famotidine, continue omeprazole." During a interview on 9/20/23 at 1:23 p.m., the DON stated the former DON was receiving and "doing" the pharmacy reviews prior to her leaving the role in January 2023. After that, the pharmacy was emailing the pharmacy reviews "for a while" but there was a DON that temporarilly filled the role. During that time, the pharmacy began using a "portal" system and the facility did not have access. There was a change in consultant pharmacists during this time. The DON was unsure of the timeline but was aware there was a time when the facility had not received pharmacy	F 756		

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F 756	Continued From page 18	F 756		

medication reviews because the facility did not get access for a "couple" of months. Review of the Consultant Pharmacist's Medication Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error.

During a telephone interview on 9/20/23 at 2:50 p.m., pharmacist-B stated all active residents were reviewed monthly and reports were generated for the facility. Pharmacist-B took over the role in May 2023; however, was able to review all recommendations prior to that because it was the same pharmacy system. Once the reports were sent to the facility, if there was a recommendation, nursing might take care of it or the report was forwarded to the medical provider. If there were no recommendations, the report would list the review as such. Typically, pharmacist-B would review the prior month's report to determine if all recommendations were responded to. If not, pharmacist-B would resend the recommendation so it would be addressed within 60 days. The consultant pharmacist role was to help the nursees to ensure all recommendations were responded to and to provide assistance to staff to meet regulation requirements. Pharmacist-B stated the facility reported to him inability to access the portal and had assisted the facility to gain access. Yes, the recommendations should have been addressed within 60 days.

The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or

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F 756	Continued From page 19 risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controllled without certain medications, or with a lower dose. However, the policy failed to identify the consultant pharmacist's role nor the timeframe when a Consulting Pharmacist's Medication Review Recommendation should be addressed.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 757	Cornerstone Nursing and Rehab Center	11/3/23

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F 757	Continued From page 20 facility failed to ensure a duplicate medication was evaluated for necessity by the physician for 2 of 5 residents (R32); failed to obtain justification for use for antibiotics for 1 of 5 residents (R2) reviewed for unnecessary medication. Findings include: R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia. The MDS failed to identify if R32 had gastroesophageal reflux disease (GERD) (A chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach) or ulcer. R32's Physician Order Report dated 7/28/23 - 8/28/23, identified the following: - 8/16/22, omeprazole (a gastric acid secretion reducer and proton pump inhibitor (PPI)) 20 milligrams (mg) capsules. One capsule by mouth once a day. - 8/17/22, famotidine (a gastric acid secretion reducer) 20 mg tablets. One tablet by mouth once a day. R32's Consulting Pharmacist's Medication Review Recommendation dated 3/28/23, identified R32 received famotidine 20 mg tablets and omeprazole 20 mg delayed release (DR) capsules . The pharmacist identified R32 continued to take both mediation and acid secretion should be adequately suppressed with the PPI alone. The pharmacist suggested to consider re-assessing the ongoing need for both acid reducers and consider discontinuing one of the medications, if possible. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review on	F 757	shall ensure each resident's drug regimen is free from unnecessary drugs through evaluation by the physician. R32 famotidine was discontinued on 9/20/23 and R2 has an appointment scheduled on 11/15/23 to see urology to address prophylactic antibiotic usage. A 72-hour antibiotic timeout form has been implemented for all residents who are prescribed an antibiotic. Nursing shall perform audits on current residents for the past 30 days, for ABX, PRN ABX, and PPIs using order by category report to check for similarities for 4 weeks and notify the physician of any irregularities. Additional Registered Nurses have been given access to the pharmacy portal to retrieve drug regimen pharmacy reviews and ensure follow up is completed in a timely manner for all resident reviews. Drug Regimen education and post-test has been completed by Registered Nurses responsible for review and follow through on pharmacy recommendations. The Director of Nursing or designee shall audit the monthly pharmacy review summary report for 3 months to ensure all recommendations are addressed in a timely manner. Facility Infection Preventionist or designee shall monitor antibiotic usage three times a week for two weeks, then weekly for two weeks and randomly thereafter. Audits shall be reviewed to ensure the 72-hour timeout form is completed timely and faxed to MD. Results shall be reviewed at QAPI to ensure compliance and to determine if additional monitoring is necessary.	

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F 757	Continued From page 21 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "discontinue famotidine, continue omeprazole". During a interview on 9/20/23 at 1:23 p.m., the director of nursing (DON) stated she was unaware of R32's duplicate medication until that morning when the Consulting Pharmacist's Medication Review Recommendation forms were requested. Reviewing The Consultant Pharmacist's Medication Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error. Nursing should have reviewed R32's medications during assessments and contacted R32's provider for guidance. R2's quarterly Minimum Data Set (MDS) dated 9/5/23, identified R2 was cognitively intact and had a suprapubic catheter. R2's diagnoses included multiple sclerosis and neurogenic bladder. R2 had taken an antibiotic one time during the assessment period. R2's urinary Care Area Assessment (CAA) dated 4/5/23, identified R2 had no signs or symptoms of UTI and took a single day a week, rotating antibiotic for prophylactic urinary tract infection (UTI). R2's care plan revised 9/13/23, identified R2 had	F 757		

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F 757	Continued From page 22	F 757		

impaired functional status and directed staff to monitor and report signs and symptoms of UTI including fever, chills, bladder spasms, and concentrated urine.

R2's physician orders report dated 7/6/23, identified R2 was prescribed the following antibiotics on 7/15/22, for UTI:
- ciprofloxacin HCL 500 mg tablet take one tablet by mouth once a day on the 1st Monday of the month.
- doxycycline hyclate 100 mg capsule take one capsule by mouth once a day on the 2nd Monday of the month.
- amoxicillin-pot clavulanate 875-125 mg take one tablet once a day on the 3rd Monday of the month.
- cephalexin 500 mg capsule take one capsule by mouth once a day on the 4th Monday of the month.

R2's pharmacy medication monitoring review (MMR) dated 9/18/22, identified the pharmacist suggested R2's doctor re-assess the ongoing use of the antibiotic's (at the current dose effectiveness would be questionable and the risk for resistance to all four antibiotics maybe increased) for chronic UTI prophylaxis. The pharmacist requested a clinical rationale if the current benefits outweighed the risks. The medical doctor (MD) rejected the suggestion and stated R2's urologist recommended the resident needed to continue the antibiotics. The MMR failed to identify when the antibiotics had been re-assessed by the urologist.

R2's progress notes identified the following:
- On 9/15/23, 7/6/23, 2/2/23, 12/8/22, 10/13/22, and 9/15/22, R2 was seen by the medical doctor

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F 757	Continued From page 23 (MD) on rounds. The notes failed to identify if the antibiotics R2 was taking had been addressed. - On 6/28/23, 4/17/23, 3/10/23, and 1/4/23, the MDS assessment notes identified R2 took a single day a week, rotating, antibiotic for prophylactic UTI. During interview on 9/20/23 at 10:47 a.m., licensed practical nurse (LPN)-A stated R2 took a different antibiotic every Monday for the first four Monday's of each month. LPN-A thought the urologist prescribed the antibiotics because R2 was prone to UTI's and had been taking them for a long time. During interview on 9/20/23 at 2:19 p.m., R2's medical doctor stated R2 had multiple UTI's in the past and the urologist wanted R2 to continue on the antibiotic regimen. R2 was the urologist in the past year. R2's urology visit notes for the last year were requested and not received. The facility failed to provide documentation that R2's medications were being reviewed by a urologist and there was justification for prophylactic antibiotic use. During interview on 9/20/23 at 1:01 p.m., the DON stated R2 was admitted on 7/15/22, and was taking the antibiotic regimen prior to admission. The DON thought the medications were reviewed upon admission but was uncertain if they had been reviewed since that time. R2's antibiotic regimen should have been reviewed by the pharmacist and the doctor since R2's admission. Inappropriate antibiotic use could lead to organisms being resistant the antibiotics used, could limit the type of antibiotics available for use by R2, could potentially be harmful to R2 and	F 757		

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F 757	Continued From page 24 other residents, and could cause R2 to receive unnecessary antibiotics. The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		11/3/23

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F 758	Continued From page 25 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an antidepressant medication had a documented rationale from the physician for continued use for 1 of 4 (R32) residents reviewed who were on psychotropic medications. Findings include: R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia, bipolar disorder and anxiety. R32 was on an	F 758	Cornerstone Nursing and Rehab Center shall ensure each resident's drug regimen is free from unnecessary psychotropic drugs. R32's primary care physician reviewed and signed the pharmacy recommendation stating resident to continue dosage. R32 has been and is being seen by a psychiatric provider to assist in managing appropriate psychotropic medications. Additional Registered Nurses have been given access to the pharmacy portal to	

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F 758	Continued From page 26 antidepressant medication. R32's psychotropic drug use Care Area Assessment (CAA) dated 7/24/23, identified R32 continued to take antidepressant without any adverse effects. R32's care plan remained current. R32's Consulting Pharmacist's Medication Review Recommendation dated 2/21/23, identified R32 received fluoxetine (an antidepressant) 20 milligrams (mg) capsules. CMS required evaluation of psychotropic medication. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted the recommendation for gradual dose reduction was "rejected" and "patient still depressed, continue." R32's physician progress notes dated 9/20/23 through 8/29/23, failed to identify the rationale for fluoxetine use. During a interview on 9/20/23 at 1:23 p.m., the director or nursing (DON) stated she was unaware of the Consulting Pharmacist's Medication Review Recommendation to obtain a rational for the use of fluoxetine until the SA requested the Consulting Pharmacist's Medication Review Recommendations. The review of the Consultant Pharmacist's Medication	F 758	retrieve drug regimen pharmacy reviews and ensure follow up is completed in a timely manner. The facility EMR psychotropic medications report shall be audited for the past 30 days for all residents receiving psychotropic medications to ensure no other residents have been affected. The Director of Nursing or designee shall monitor and track psychotropic medication use and last GDR date for those residents on psychotropic medications to ensure on-going compliance. Registered Nurses responsible for monitoring psychotropic medication use shall be educated on facility GDR policy and psychotropic medication policy. Results shall be reviewed at QAPI to ensure compliance and to determine if additional monitoring is necessary.	

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F 758	Continued From page 27 Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error. The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controllled without certain medications, or with a lower dose.	F 758		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate indications and resistance for use of an antibiotic for 2 of 2 residents (R12, R2). Findings include:	F 881	Cornerstone Nursing and Rehab Center's infection prevention and control program shall include an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. R12 completed Augmentin 875mg-125mg on 7/24/23 and was seen by primary care	11/3/23

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F 881	Continued From page 28 R12's quarterly Minimal Data Set (MDS) dated 8/25/23, identified R12 had diagnoses that included anxiety, respiratory failure, chronic obstructive pulmunary disease (COPD) and hyperlipidemia (high cholesterol). The MDS did not identify R12 utilized antibiotics. R12's Physician Order Report dated 6/30/23-7/31-23, identified the following: - 5/31/23 - 6/7/23, amoxicillin potassium clavulanate 875-125 miligram (mg) 1 tablet by mouth twice a day. - 7/14/23 - 7/24/23, amoxicillin potassium clavulanate 875-125 miligram (mg) 1 tablet by mouth twice a day. R12's nursing progress notes identified the following: -6/27/23 at 1:51 p.m., R12 was seen by his provider on rounds. The provider evaluated R12's lower extremity swelling and redness. R12 was on three courses of antibiotics for cellulities (a bacterial skin infection) and his provider wanted to see how R12 did without antibiotics. - 7/14/23 at 9:52 a.m., a call was placed to R12's provider regarding R12's increased redness in leg and thigh as well as swelling and pain. Nursing received orders for Augmentin 875-125mg by mouth twice a day for 10 days. - 7/17/23 at 3:22 p.m., nursing attempted to call R12's provider regarding R12's lower extremity to discuss the possibility of an ultrasound rule out blood clot. A message was left for R12's clinic nurse to return call. R12's medical record lacked further documentation regarding R12's antibiotic treatment.	F 881	physician on 8/1/23 stating RLE was back to baseline. R2 has an appointment scheduled on 11/15/23 to see urology to address prophylactic antibiotic usage. The Director of Nursing or designee shall perform audit on current residents for the last 30 days, for ABX and PRN ABX using order by category report to check for similarities to ensure no other residents were affected. A 72-hour antibiotic timeout form has been implemented for all residents who are prescribed an antibiotic. Licensed staff shall be educated on utilization and follow-up of 72-hour time out form. Infection Preventionist nurse educated on antibiotic stewardship. Facility Infection Preventionist or designee shall monitor antibiotic usage three times a week for two weeks, then weekly for two weeks and randomly thereafter. Audits shall be reviewed to ensure 72-hour timeout form is completed timely faxed to MD. Results shall be reviewed at QAPI to ensure compliance and to determine if additional monitoring is necessary.	

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F 881	Continued From page 29 During an interview on 9/20/23 at 10:18 a.m., the director of nursing (DON) stated ideally when a resident was started on an antibiotic, like for instance, a UTI, nursing requested to get a urine culture to ensure the bacteria was sensitive to antibiotics. Nursing tried to follow through with that. Ideally, nursing would complete a form that would be sent to the resident's provider to show why the antibiotic was needed, if the antibiotic needed to be reassessed and/or if the antibiotic should be stopped. The DON had not done an antibiotic review in a long time because she had too much to do and it was put on the back burner. R12 had been on many different antibiotics. Many tests were collected and it was never really determined what was wrong. R12 was treated with antibiotics to see if it would help, but the provider stated it was just R12's "baseline." R2's quarterly Minimum Data Set (MDS) dated 9/5/23, identified diagnoses of multiple sclerosis (MS), neurogenic bladder, and had a suprapubic catheter in place. R2 had taken antibiotics one time during the assessment period. R2's physician order report dated 7/6/23, identified R2 was prescribed the following antibiotics on 7/15/22, for urinary tract infection (UTI): - ciprofloxacin HCL 500 mg tablet take one tablet by mouth once a day on the 1st Monday of the month. - doxycycline hyclate 100 mg capsule take one capsule by mouth once a day on the 2nd Monday of the month. - amoxicillin-pot clavulanate 875-125 mg take one	F 881		

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F 881	Continued From page 30	F 881		

tablet once a day on the 3rd Monday of the month.
- cephalexin 500 mg capsule take one capsule by mouth once a day on the 4th Monday of the month.

R2's progress notes identified the following:
- 9/15/23, 7/6/23, 2/2/23, 12/8/22, 10/13/22, and 9/15/22, R2 was seen by the medical doctor (MD) on rounds. The notes failed to identify if the antibiotics R2 was taking had been addressed.
- 6/28/23, 4/17/23, 3/10/23, and 1/4/23, the MDS assessment notes identified R2 took a single day a week, rotating, antibiotic for prophylactic UTI.

During interview on 9/20/23 at 10:47 a.m., licensed practical nurse (LPN)-A stated R2 was admitted to the facility on 7/15/22. R2 had UTI's and was taking the antibiotic cycle prior to being admitted. LPN-A thought R2's antibiotic cycle was ordered by the urologist but was uncertain where the order originally came from.

During interview on 9/20/23 at 1:01 p.m., the director of nursing (DON) stated R2 was admitted on 7/15/22, and was taking a one day per week, rotating antibiotic cycle for a very long time prior to admission. The DON was unable to identify when the antibiotics were originally prescribed or by whom. Since R2's admission, the doctor and the pharmacist should have addressed R2's antibiotic and provided a rationale for use. Inappropriate use of antibiotics could lead to resistant organisms which could limit the antibiotics the resident could use and potentially be harmful to R2 or other residents.

The facility Antibiotic Stewardship Policy and Procedure dated , identified the purpose was to

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F 881	Continued From page 31 develop and maintain guidelines about facility staff expectations to develop and implement a system to ensure residents received the appropriate antibiotics, reduce risk/adverse events and strive for quality outcomes, this would include a system for monitoring to improve resident outcomes and reduce antibiotic resistant organisms or negative outcomes. The procedure directed the IP to track antibiotic use including type, dose, duration, prescribing practitioner, and appropriate diagnosis. The IP would also monitor adherence to evidence-based criteria including: documenation related to antibiotic selection and use, tracking antibiotics used to review patterns/trends of use and determine impact of hte antibiotic stewardship interventions, monitor for clinical outcomes such as adverse events, antibiotic resistant organisms and C-diff.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		11/3/23

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F 883	Continued From page 32 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the most recent Centers	F 883	Cornerstone Nursing and Rehab Center strives to ensure each resident is offered	

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	245307	A. BUILDING _____ B. WING _____	C 09/20/2023

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F 883	Continued From page 33 for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 5 of 5 residents (R2, R16, R32, R37, R40) reviewed for immunizations. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/5/23, identified R2 was admitted to the facility on 7/15/22, was 74 years old and had diagnoses that included hypertension, renal failure, and multiple sclerosis (MS). R2's undated, Preventative Health Care immunization record, identified R2 received the PPSV23 on 3/9/15, and the PCV13 on 9/16/16. R2's EHR did not include evidence R2 or R2's representative received education regarding pneumococcal vaccine booster and there was no indication R2 was offered the pneumococcal vaccine per CDC guidance. R16's significant change MDS dated 8/22/23, identified R16 was admitted to the facility on 7/12/23, was 93 years old. R16's undated Preventative Health Care immunization record identified R16 refused pneumococcal vaccination due to "conscientious objection". However, R16's EHR did not include evidence R16 or R16's representative received education regarding pneumococcal vaccine. R32's annual MDS dated 7/24/23, identified R32 was admitted to the facility on 8/16/22, was 78 years old and had diagnoses that included hypertension and dementia. R32's undated, Preventative Health Care	F 883	the appropriate information for receiving the Influenza and Pneumococcal vaccines. R2, R16, R32, R37, and R40 have been offered pneumonia vaccine and provided education regarding the potential risks and benefits of the vaccines. Audit was completed on current residents for pneumococcal and flu vaccinations, all eligible residents were offered the vaccine and has been documented. Licensed staff shall be educated on CDC guidelines of vaccines. Vaccine Information Sheets and consent form have been added to the admission packet to ensure all residents are offered and educated on vaccines. The Director of Nursing or designee shall complete audits on all new admissions weekly for four weeks, then every other week for four weeks and randomly thereafter to ensure influenza and pneumococcal immunizations and information is offered and documented. Results shall be reviewed at QAPI to ensure compliance and determine if additional monitoring is necessary.	

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F 883	Continued From page 34 immunization record, identified R32 received the PCV13 on 10/27/14. R32's EHR did not include evidence R32 or R32's representative received education regarding pneumococcal vaccine booster and there was no indication R32 was offered the pneumococcal vaccine per CDC guidance. R37's quarterly Minimum Data Set (MDS) dated 9/8/23, identified R37 was admitted to the facility 3/27/23, was 61 years old and had diagnoses that included non-traumatic brain dysfunction, diabetes and dementia. R37's undated Preventative Health Care immunization record, failed to identify if R37 received a pneumococcal vaccine. R37's EHR did not include evidence R37 or R37's representative received education regarding pneumococcal vaccine and there was no indication R37 was offered the pneumococcal vaccine per CDC guidance. R40's significant change MDS dated 7/20/23, identified R40 was admitted to the facility on 6/23/23, was 76 years old and had diagnoses included anemia, malnutrition and chronic obstructive pulmonary disease (COPD). R40's undated, Preventative Health Care immunization record undated identified R40 received the PCV13 on 1/18/14. R40's EHR did not include evidence R40 or R40's representative received education regarding pneumococcal vaccine booster and there was no indication R40 was offered the pneumococcal vaccine per CDC guidance. During interview on 9/19/23 at 3:25 p.m.,	F 883		

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F 883	Continued From page 35 registered nurse (RN)-A stated when a resident was admitted, nursing reviewed the resident's medical record for immunizations. If the resident was not up to date, the facility offered the immunizations. RN-A had never offered nor administered a pneumococcal vaccine at the facility and was unaware of pneumococcal vaccine guidance. During an interview on 9/20/23 at 10:40 a.m., the director of nursing (DON) stated she was aware of updated pneumococcal guidelines and the pharmacy sent a list of residents who qualified for pneumococcal vaccination. The DON wanted to schedule a vaccine "clinic" at the facility in order to administer all needed vaccines at the same time; however, staff began administering influenza vaccines but had not offered pneumococcal vaccines yet. The DON created an immunization checklist for a resident's admission but had not implemented the checklist yet. The facility policy Pneumococcal Vaccine revised 10/17/22, identified upon admission, residents would be assessed for eligibility to receive pneumococcal vaccine and when indicated, would be offered one of the pneumococcal vaccines within thirty days of admission unless medically contraindicated. Before receiving either of the pneumococcal vaccines, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education would be documented in the resident's medical record. The facility copy of the Pneumococcal Vaccine Information Sheet was requested but not received.	F 883		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2023

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

Re: State Nursing Home Licensing Orders
Event ID: 6DTP11

Dear Administrator:

The above facility was surveyed on September 18, 2023 through September 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/18/23 through 9/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint(s) were reviewed: H53075593C (MN95998) with no licensing orders ; and H53075592C (MN91452) with a licensing order issued at 4658.0135 Subp. 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		10/20/23

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to inform the physician of a medication error for 1 of 5 residents (R32)reviewed unnecessary medications. Findings include: R32's annual Minimum Data Set (MDS) dated 7/24/23, included a diagnosis of hypertension. R32's physician order dated 8/17/22, identified R32 was to receive amlodipine (a blood pressure medication) 5 miligrams (mg) by mouth every day. R32's Medication Administration History dated 9/1/23 through 9/20/23, identified the following: - On 9/1/23, R32 was not administered amlodipine due to "medication was not there, pharmacy called". - On 9/2/23, R32 was not administered amlodipine due to "unavailable". - On 9/3/23, R32 was not administered amlodipine due to "unavailable". - On 9/4/23, R32 was not administered amlodipine due to "unavailable". - On 9/5/23, R32 was not administered amlodipine due to "unavailable". - On 9/6/23, R32 was not administered amlodipine due to "unavailable". - On 9/7/23, R32 was not administered	2 265	corrected	

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2 265	Continued From page 4 amlodipine due to "unavailable". - On 9/8/23, R32 was not administered amlodipine due to "unavailable". - On 9/9/23, R32 was not administered amlodipine due to "unavailable". - On 9/10/23, R32's amlodipine was administered - On 9/11/23,R32 was not administered amlodipine due to "unavailable". R32's nursing progress note dated 9/11/23 at 10:49 a.m., identified R32's amlodipine medication card was missing since 9/10/23. The pharmacy was called and the pharmacy would deliver the medication that evening. The note failed to identify if R32's physician was notified of the repeated medication errors. During an interview on 9/20/23 at 10:05 a.m., licensed practical nurse (LPN)-A stated when a medication was missing, she would first check the rest of the cart to ensure it was not placed in the wrong area, then check the medicaiton room to make sure it wasn't missed after a pharmacy delivery. If the medication still could not be found, LPN-A would call the pharmacy to ask that it be delivered. If the pharmacy could not deliver the medication or if there was a medication error, the physician would be notified to determine next steps. Physician notification was important because, ultimately, the physician had say over all medications and it could affect a resident's care. For example a resident missing a dose of vitamin may not be a big deal, but missing a blood pressure medication could lead to a stroke. LPN-A did not administer R32's medication because the medication was missing and could not recall if she had contacted the pharmacy nor R32's physician. During an interview on 9/20/23 at 10:37 a.m., the	2 265		

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2 265	Continued From page 5 director of nursing (DON) stated she would expect nursing to perform a full resident assessment when a medication error occurred, notify the pharmacy of the needed medication, and to notify the resident's physician to request guidance. In addition, the nursing staff were expected to fill out a medication error form which was submitted to the DON for investigation. The DON stated was unaware of R32's missing amlodipine and was unable to locate a completed medication error form for R32. During a telephone interview on 9/20/23 at 11:15 a.m., pharmacist-A stated the pharmacy received a call from the facility on 9/11/23, requesting R32's amlodipine. The previous cart exchange was delivered on 8/31/23 and would have been used 9/1/23-9/14/23. If a medication was missing, normally, the facility would call as soon as it was found. The pharmacy does ask facility staff to go through all the delivery boxes to ensure it was not missed but would deliver the medication the same day. Amlodipine stopped abruptly could cause an elevated blood pressure that could potentially lead toa higher risk for complications such as stroke. During a telephone interview on 9/20/23 at 2:05 p.m., R32's physician stated he was not informed of R32's medication error. The physician stated he never had this happen before but would expect nursing to contact him in the first 24 hours to inform him R32 did not have medication. The physician would contact the pharmacy to ensure R32 would receive her scheduled medications. Secondly, the physician would expect nursing to assess R32, especially R32's blood pressure, because not having a medication could lead to an increase in blood pressure and complications could ensue.	2 265		

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2 265	Continued From page 6 The facility policy Medication Error Reporting revised 8/24/22, identified the medication error was to be reported immediately when noted to the DON or charge nurse. The DON or charge nuse would take proper action and steps to ensure the safety of the resident and assess need to immediately notify the physician. The person finding the medication error would correct, when able, and fill out the Medication Error Form and file with the DON. Documentation was to be made by the person finding the error in the Medication Error Form. The DON or as designated by the DON shall review with the individual who made the error and provide education and means to prevent further errors. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise medication error practices to include notification to the medical provider; inservice nursing staff regarding the timely notification of the medical provider; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 340	MN Rule 4658.0135 Subp. 1,2 Policy Records Subpart 1. Availability of policies. All policies and procedures directly related to resident care adopted by the home must be placed on file and be made available upon request to nursing home personnel, residents, legal representatives, and designated representatives. Subp. 2. Admission policies. Admission policies must be made available upon request to prospective residents, family members, legal	2 340		10/20/23

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2 340	Continued From page 7 representatives, and designated representatives. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to readmit residents after a hospitalization for 1 of 1 resident (R147) reviewed for discharge. Findings include: R147's discharge Minimum Data Set (MDS) dated 2/20/23, identified R147 was discharged on 2/20/23, with facility return anticipated. R147 had severe cognitive impairment. Diagnosis included chronic obstructive pulmonary disease (COPD) and R147 had shortness of breath or trouble breathing with exertion, at rest and when lying flat. R147's progress notes identified the following: - 2/20/23 at 5:09 a.m., R147 was transferred to the emergency department (ED) and later that morning was admitted to the hospital. - 2/22/23, R147's son contacted the facility reporting R147 may be ready for discharge and he wanted R147 to return to the facility that same day. R147's son was told by facility staff they would not be able to readmit the resident after 1:00 p.m. due to staff shortage. - 2/24/23 at 12:07 p.m., the facility received an update from the hospital case manager identifying a decline in R147 condition and the plan was to discuss possible comfort cares for the resident. - 2/25/23 through 2/26/23, R147's progress notes failed to identify communication between the facility and hospital regarding discharge planning.	2 340	Corrected	

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2 340	Continued From page 8 R147 hospital notes identified the following: - 2/20/23, R147's emergency department (ED) visit notes identified R147 arrived at the ED at 5:12 a.m. and was admitted to the hospital for further care. - 2/25/23 at 10:00 p.m., the medical center daily progress notes identified R147's family decided to place R147 comfort cares and planned to discharge R147 back to the nursing home for hospice care. R147's progress notes identified the following: - 2/27/23 at 10:08 a.m., the Long-Term Care Ombudsman left a voicemail for the administrator on 2/25/23, and the administrator returned the call and left a voicemail. The hospital wanted to transfer R147 back to the facility on 2/25/23, but the facility had been unable to accept the resident. The progress notes failed to identify why R147 was not accepted for transfer. - 2/27/23 at 11:03, R147's son provided an update to the facility regarding the residents declining health status. R147's family had wanted R147 to return to the facility. On 9/19/23 at 3:34 p.m., a phone call was attempted to reach the facility ombudsman's and was notified the ombudsman was out of the office until 9/26/23. During interview on 9/19/23 at 3:12 p.m., the social worker (SW) stated when a resident was transferred out of the facility, the nurses were responsible for obtaining a written or verbal consent for a bed hold indicating the facility would accept the resident back when they were medically stable. Staffing should not affect when a resident is readmitted to the facility. According to R147's progress notes, the hospital case	2 340		

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2 340	Continued From page 9 manager called inquiring about readmitting the resident back to the facility but the facility was unable to readmit due to not having a registered nurse (RN) available to re-admit the R147. During interview on 9/20/23 at 8:38 a.m., the hospital case manager (CM) stated On 2/20/22, R147 was admitted to the hospital for acute care. On 2/22/253, R147's family elected comfort care due to R147's decline in health. On 2/23/23, the hospital talked with R147's son who was trying to coordinate a care conference with the facility to update on residents' health status. On 2/24/23, the hospital case manager talked with the nursing home staff who stated they would be able to provide comfort cares for R147 but they were unable to readmit the resident over the weekend due to no RN coverage. R147's family verbally agreed to a bed hold for R147, which meant the facility agreed to and could not refuse to readmit the resident when they were medically stable. CM would expect the facility to readmit even on a weekend. During interview on 9/20/23 at 12:27 p.m., the director of nursing (DON) stated when a resident was transferred to the hospital, the facility would work with the hospital case manager to accommodate the residents needs and plans for readmission, including readmissions on the weekends. The facility was currently only taking readmissions during the work week because that is when the admitting nurses worked. R147 should have been readmitted to the facility and received comfort cares in R147's home. By not readmitting over the weekend R147 was not allowed to die at R147's home where she was comfortable with her family nearby. R147's progress noted lacked evidence of thorough discharge and readmission plans. Due of the lack	2 340		

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2 340	Continued From page 10 of documentation in R147's progress notes the DON was unable to determine if the facility provided a good faith effort to readmit R147. The facility Notice of Bed Hold Policy and Return reviewed 10/24/22, identified a resident would be readmitted to the facility to the first available bed if the facility could meet their needs. A readmission policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON/ Administror or designee could review and revise readmission to the facility procedures; inservice nursing staff regarding the expectations; and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 340		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next	21530		10/20/23

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21530	Continued From page 11 physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure pharmacy consultants recommendations were followed up on in a timely manner for 3 of 5 residents (R29, R32) reviewed for medication management. Finding included: R29's quarterly Minimum Data Set (MDS) dated 8/4/23, identified R29 had moderate cognitive impairment with diagnoses of non-Alzheimer's dementia, and Huntington's disease (a rare, inherited disease that causes the progressive breakdown (degeneration) of nerve cells in the	21530	Corrected	

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21530	Continued From page 12 brain). R2 received antianxiety and antidepressant medications. R29's Consulting Pharmacist's Medication Review Physician Recommendation dated 3/23/23, identified R29 received trazodone (an antidepressant and sedative) 50 milligram (mg) tablets. The Centers for Medicare and Medicaid Services (CMS) required evaluation of psychotropic (medications which affect a person's mental state) medications. This was to be addressed as soon as possible but no later than 60 days. R29's medical provider reviewed and signed off on the Consulting Pharmacist Medication Review on 9/20/23. It was over 180 days after recommendation was given and was only addressed after the surveyor requested the information. The provider noted "drug d/c (discontinued) already" and was rejected but did not identify when if it happened. During an interview on 9/20/23 at 1:27 p.m., the director of nursing (DON) stated there as a period of time where the facility did not received any Consultant Pharmacist's Medication Reviews through pharmacy portal and some may have been missed. The facility did not call the pharmacy to request the medication reviews. The medication reviews would be expected to be addressed within the stated time periods to ensure residents were not receiving unnecessary medications. The medication review from 3/23/23, was not addressed until 9/20/23, after survey entered.. R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia, hypertension, bipolar disorder and anxiety. R32 utilized antipsychotic, antidepressant and anticoagulant medications.	21530		

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21530	Continued From page 13 R32's Consulting Pharmacist's Medication Review Recommendation dated 1/18/23, identified R32 received famotidine (a gastric acid secretion reducer) 20 mg tablets. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Mediation Review dated 1/18/23, and noted "pros greater than cons." R32's Consulting Pharmacist's Medication Review Recommendation dated 2/21/23, identified R32 received fluoxetine (an antidepressant) 20 mg capsules. CMS required evaluation of psychotropic medication. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "patient still depressed, continue." R32's Consulting Pharmacist's Medication Review Recommendation dated 3/28/23, identified R32 received famotidine (a gastric acid secretion reducer) 20 mg tablets and omeprazole (a gastric acid secretion reducer and proton pump inhibitor (PPI)) 20 mg delayed release (DR) capsules . The pharmacist identified R32 continued to take both mediation and acid secretion should be adequately suppressed with the PPI alone. The pharmacist suggested to	21530		

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21530	Continued From page 14 consider re-assessing the ongoing need for both acid reducers and consider discontinuing one of the medications, if possible. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review dated on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "discontinue famotidine, continue omeprazole." During a interview on 9/20/23 at 1:23 p.m., the DON stated the former DON was receiving and "doing" the pharmacy reviews prior to her leaving the role in January 2023. After that, the pharmacy was emailing the pharmacy reviews "for a while" but there was a DON that temporarilly filled the role. During that time, the pharmacy began using a "portal" system and the facility did not have access. There was a change in consultant pharmacists during this time. The DON was unsure of the timeline but was aware there was a time when the facility had not received pharmacy medication reviews because the facility did not get access for a "couple" of months. Review of the Consultant Pharmacist's Medication Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error. During a telephone interview on 9/20/23 at 2:50 p.m., pharmacist-B stated all active residents were reviewed monthly and reports were generated for the facility. Pharmacist-B took over the role in May 2023; however, was able to review all recommendations prior to that because it was the same pharmacy system. Once the reports were sent to the facility, if there was a recommendation, nursing might take care of it or	21530		

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21530	Continued From page 15 the report was forwarded to the medical provider. If there were no recommendations, the report would list the review as such. Typically, pharmacist-B would review the prior month's report to determine if all recommendations were responded to. If not, pharmacist-B would resend the recommendation so it would be addressed within 60 days. The consultant pharmacist role was to help the nursees to ensure all recommendations were responded to and to provide assistance to staff to meet regulation requirements. Pharmacist-B stated the facility reported to him inability to access the portal and had assisted the facility to gain access. Yes, the recommendations should have been addressed within 60 days. The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controllled without certain medications, or with a lower dose. However, the policy failed to identify the consultant pharmacist's role nor the timeframe when a Consulting Pharmacist's Medication Review Recommendation should be addressed. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies regarding the pharmacist and the facilities responsibilities regarding the medication reviews; inservice nursing staff; then audit to ensure compliance.	21530		

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21530	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a duplicate medication was evaluated for necessity by the physician for 2 of 5 residents (R32); failed to obtain justification for use for antibiotics for 1 of 5 residents (R2) reviewed for unnecessary medication.	21535	Corrected	10/20/23

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21535	Continued From page 17 Findings include: R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia. The MDS failed to identify if R32 had gastroesophageal reflux disease (GERD) (A chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach) or ulcer. R32's Physician Order Report dated 7/28/23 - 8/28/23, identified the following: - 8/16/22, omeprazole (a gastric acid secretion reducer and proton pump inhibitor (PPI)) 20 milligrams (mg) capsules. One capsule by mouth once a day. - 8/17/22, famotidine (a gastric acid secretion reducer) 20 mg tablets. One tablet by mouth once a day. R32's Consulting Pharmacist's Medication Review Recommendation dated 3/28/23, identified R32 received famotidine 20 mg tablets and omeprazole 20 mg delayed release (DR) capsules . The pharmacist identified R32 continued to take both mediation and acid secretion should be adequately suppressed with the PPI alone. The pharmacist suggested to consider re-assessing the ongoing need for both acid reducers and consider discontinuing one of the medications, if possible. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted "discontinue famotidine, continue omeprazole".	21535		

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21535	Continued From page 18 During a interview on 9/20/23 at 1:23 p.m., the director of nursing (DON) stated she was unaware of R32's duplicate medication until that morning when the Consulting Pharmacist's Medication Review Recommendation forms were requested. Reviewing The Consultant Pharmacist's Medication Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error. Nursing should have reviewed R32's medications during assessments and contacted R32's provider for guidance. R2's quarterly Minimum Data Set (MDS) dated 9/5/23, identified R2 was cognitively intact and had a suprapubic catheter. R2's diagnoses included multiple sclerosis and neurogenic bladder. R2 had taken an antibiotic one time during the assessment period. R2's urinary Care Area Assessment (CAA) dated 4/5/23, identified R2 had no signs or symptoms of UTI and took a single day a week, rotating antibiotic for prophylactic urinary tract infection (UTI). R2's care plan revised 9/13/23, identified R2 had impaired functional status and directed staff to monitor and report signs and symptoms of UTI including fever, chills, bladder spasms, and concentrated urine. R2's physician orders report dated 7/6/23, identified R2 was prescribed the following antibiotics on 7/15/22, for UTI: - ciprofloxacin HCL 500 mg tablet take one tablet by mouth once a day on the 1st Monday of the month. - doxycycline hyclate 100 mg capsule take one	21535		

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21535	Continued From page 19 capsule by mouth once a day on the 2nd Monday of the month. - amoxicillin-pot clavulanate 875-125 mg take one tablet once a day on the 3rd Monday of the month. - cephalexin 500 mg capsule take one capsule by mouth once a day on the 4th Monday of the month. R2's pharmacy medication monitoring review (MMR) dated 9/18/22, identified the pharmacist suggested R2's doctor re-assess the ongoing use of the antibiotic's (at the current dose effectiveness would be questionable and the risk for resistance to all four antibiotics maybe increased) for chronic UTI prophylaxis. The pharmacist requested a clinical rationale if the current benefits outweighed the risks. The medical doctor (MD) rejected the suggestion and stated R2's urologist recommended the resident needed to continue the antibiotics. The MMR failed to identify when the antibiotics had been re-assessed by the urologist. R2's progress notes identified the following: - On 9/15/23, 7/6/23, 2/2/23, 12/8/22, 10/13/22, and 9/15/22, R2 was seen by the medical doctor (MD) on rounds. The notes failed to identify if the antibiotics R2 was taking had been addressed. - On 6/28/23, 4/17/23, 3/10/23, and 1/4/23, the MDS assessment notes identified R2 took a single day a week, rotating, antibiotic for prophylactic UTI. During interview on 9/20/23 at 10:47 a.m., licensed practical nurse (LPN)-A stated R2 took a different antibiotic every Monday for the first four Monday's of each month. LPN-A thought the urologist prescribed the antibiotics because R2 was prone to UTI's and had been taking them for	21535		

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21535	Continued From page 20 a long time. During interview on 9/20/23 at 2:19 p.m., R2's medical doctor stated R2 had multiple UTI's in the past and the urologist wanted R2 to continue on the antibiotic regimen. R2 was the urologist in the past year. R2's urology visit notes for the last year were requested and not received. The facility failed to provide documentation that R2's medications were being reviewed by a urologist and there was justification for prophylactic antibiotic use. During interview on 9/20/23 at 1:01 p.m., the DON stated R2 was admitted on 7/15/22, and was taking the antibiotic regimen prior to admission. The DON thought the medications were reviewed upon admission but was uncertain if they had been reviewed since that time. R2's antibiotic regimen should have been reviewed by the pharmacist and the doctor since R2's admission. Inappropriate antibiotic use could lead to organisms being resistant the antibiotics used, could limit the type of antibiotics available for use by R2, could potentially be harmful to R2 and other residents, and could cause R2 to receive unnecessary antibiotics. The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 09/20/2023

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21535	Continued From page 21 Based on interview and document review, the facility failed to ensure an antidepressant medication had a documented rationale from the physician for continued use for 1 of 4 (R32) residents reviewed who were on psychotropic medications. Findings include: R32's annual MDS dated 7/24/23, identified R32 had diagnoses that included dementia, bipolar disorder and anxiety. R32 was on an antidepressant medication. R32's psychotropic drug use Care Area Assessment (CAA) dated 7/24/23, identified R32 continued to take antidepressant without any adverse effects. R32's care plan remained current. R32's Consulting Pharmacist's Medication Review Recommendation dated 2/21/23, identified R32 received fluoxetine (an antidepressant) 20 milligrams (mg) capsules. CMS required evaluation of psychotropic medication. The pharmacist suggested to either consider a dose reduction (only if appropriate) or to document (with clinical rationale) why the current benefits outweighed the risks to stay on the current dose. R32's medical provider reviewed and signed off on the Consulting Pharmacist Medication review on 9/20/23. It was over 180 days after the recommendation was given and only addressed after the State Agency (SA) requested the information. The provider noted the recommendation for gradual dose reduction was "rejected" and "patient still depressed, continue."	21535		

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21535	Continued From page 22 R32's physician progress notes dated 9/20/23 through 8/29/23, failed to identify the rationale for fluoxetine use. During a interview on 9/20/23 at 1:23 p.m., the director or nursing (DON) stated she was unaware of the Consulting Pharmacist's Medication Review Recommendation to obtain a rational for the use of fluoxetine until the SA requested the Consulting Pharmacist's Medication Review Recommendations. The review of the Consultant Pharmacist's Medication Review Recommendations in a timely manner was important because it could potentially lead to the use of unnecessary medication or a medication error. The facility policy Pharmacy Services Overview dated 11/14/22, identified the physician would review periodically whether current medications were still necessary in their current doses; for example, whether an individual's conditions or risk factors were sufficiently prominent or enduring that they require medication therapy to continue the current dose, or whether those conditions and risks could potentially be equally well managed or controllled without certain medications, or with a lower dose. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies regarding duplicate medication therapy. justification for continued use and gradual dose reductions; inservice nursing staff; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/22/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/22/2023 . At the time of this survey, Cornerstone Nursing & Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/13/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction. The 1968 building was completely remodeled at that time. The two types of construction are not separated by a 2 hour fire	K 000		

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K 000	Continued From page 2 barrier but meets all the requirements to be surveyed as one, type V (111) building. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 47 beds and had a census of 45 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		10/20/23

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K 353	Continued From page 3 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 09/22/2023, between 9:30am and 1:30pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1) Clerical Office 2) End of 400 Wing 3) Lower Level Storage Room An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 353	All items have been removed from the top of the storage racks to ensure there is at least an 18-inch clearance area under the sprinkler heads in the clerical office, the end of the 400 wing and in the lower-level storage room. All other potential areas throughout the facility have been inspected for compliance. Audits of these areas as well as all other areas throughout the facility will be completed weekly for 4 weeks, monthly for 2 months, and quarterly thereafter. These audits have been added to the facility preventative maintenance program to ensure compliance. The Environmental Services Supervisor shall be responsible for ensuring audits are completed and compliance is maintained. Results shall be reviewed at QAPI to ensure compliance and determine if additional monitoring is necessary.	