

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

Minnesota Department of Health

Kumalu Fiske-Downing

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

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

Minnesota Department of Health

Kumalu Fiske Downing

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.

Cornerstone Nsg & Rehab Center October 4, 2023 Page 2

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

Cornerstone Nsg & Rehab Center October 4, 2023 Page 3

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.

Cornerstone Nsg & Rehab Center October 4, 2023 Page 4

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

Minnesota Department of Health

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245307		B. WING		C 09/20/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2023	
CORNER	STONE NSG & REHA	AB CENTER		416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
F 000	compliance with App Preparedness Requirements accepted to a survey. The facility of the facility of the facility is enrolled signature is not require acknowledge receip INITIAL COMMENT On 9/18/23 through recertification survers facility. A complaint conducted. Your facility. A complaint conducted. Your facility of the following composite H53075593C (MN9 H53075592C (MN9 H53075)C (MN	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS 1 9/20/23, a standard by was conducted at your investigation was also cility was NOT in compliance at sof 42 CFR 483, Subpart B, and Term Care Facilities. 1 Solution of the electronic documents of 42 CFR 483, Subpart B, and Term Care Facilities. 2 Solution of the electronic documents of the electron (POC) will serve from the electronic dependence of the compliance of th		00			
	onsite revisit of you	r facility may be conducted to ntial compliance with the					
ABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	_	(X6) DATE	

10/13/2023

Electronically Signed

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		A. BUILDIN	IPLE CONSTRUCTION IG	COMPLETED		
		245307	B. WING _		09/20/2023	
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	§483.10(g)(14) Note (i) A facility must in consult with the resconsistent with his representative(s) with (A) An accident inversults in injury and physician intervent (B) A significant change in restatus in either lifectinical complication (C) A need to alter a need to discontinutreatment due to accommence a new (D) A decision to the resident from the fastas.15(c)(1)(ii). (ii) When making making making in (14)(i) of this section all pertinent information is available and prophysician. (iii) The facility must resident and the re	tification of Changes. Inmediately inform the resident; Isident's physician; and notify, I or her authority, the resident I when there is- I volving the resident which I has the potential for requiring I ion; I ange in the resident's physical, I isocial status (that is, a I is in the resident's physical, I isocial status (that is, a I is in the resident's physical, I isocial status (that is, a I is in the resident's physical, I isocial status (that is, a I is in the resident's physical, I isocial status (that is, a I is in the resident's physical, I is in the resident's physical, I is in the resident's physical, I is in the resident in section or the I is in the resident in section of the I is in the resident paragraph (g) I is in the facility must ensure that I is a specified in section of the I is also promptly notify the I is also	F 58			1/3/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	that is a composite §483.5) must discledits physical configurations that composite part, and must spectroom changes betworder §483.15(c)(9). This REQUIREMENT by: Based on interview facility failed to informedication error for (R32) reviewed unnumber findings include: R32's annual Minimal 7/24/23, included a R32's physician or R32 was to receive medication) 5 miligration and pharmacy called and pharmac	and document review, the rm the physician of a r 1 of 5 residents ecessary medications. The dated 8/17/22, identified amlodipine (a blood pressure rams (mg) by mouth every dministration History dated b/23, identified the following: as not administered medication was not there, as not administered unavailable". as not administered unavailable". as not administered unavailable". as not administered unavailable".		Cornerstone Nursing and Rehab of Strives to provide timely notification resident, physician and resident representative when there is a charmedication administration, includin medication errors. R32's amlodiping medication was obtained from pharmedication as per order. The physical was notified of R32 medication error audit has been completed on all responsively and form have been affected. The facility Medication Error Report for the past 30 days to ensure other residents have been affected. The facility Medication Error Report policy and form have been updated. 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-tigiven to ensure understanding and competency. Licensed nursing staff attendance shall be educated with post-test prior to next scheduled shall be provided the post-test prior to next scheduled shall administration compliance resources.	nge in genermacy sician sidents oliance re no l. ting d and cation est was lift not in hift. He shall	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 580	not recall if she had R32's physician. During an interview director of nursing expect nursing to passessment when notify the pharmacy and to notify the reguidance. In additional expected to fill out was submitted to the DON stated was unamlodipine and was medication error for During a telephone a.m., pharmacist-A a call from the facil R32's amlodipine. Was delivered on 8 used 9/1/23-9/14/2 normally, the facility found. The pharmac through all the delivered but would cause an elevated potentially lead to a such as stroke. During a telephone p.m., R32's physici of R32's medication he never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this he expect nursing to compose the never had this head.	ation was missing and could contacted the pharmacy nor on 9/20/23 at 10:37 a.m., the (DON) stated she would erform a full resident a medication error occurred, of the needed medication, sident's physician to request on, the nursing staff were a medication error form which he DON for investigation. The naware of R32's missing s unable to locate a completed	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIGIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) 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 or Medicaid nursing facility that determines that a resident who was transferred with an expectation of returning 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 (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 shortness of breath or trouble discharges using the facility.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED	
INME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER INVA 1D PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) FREED TAG (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (I) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, the facility to which a resident returns is a composite distinct part. When the facility to which a resident returns is a composite distinct part when the option to return to that location at the time of return, the resident must be given the option to return to 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 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 220/23, with facility return anticipated. R147' had severe cognitive impairment. Diagnosis included chronic obstructive pulmonary disease (COPD)			245307	B. WING		09/	C 20/2023
(A) Description of the composite distinct part in which he or she resided previously. If a bed there. This REGUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to readmit residents and interview and document review, the facility failed to readmit residents after a hospitalization for 1 of 1 resident (R147) reviewed for discharge. BAGLEY, MN 56621 PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (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, must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to 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 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: 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 diseases (COPD)	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	
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(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 services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to 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, with facility return anticipated. R147 had severe cognitive impairment. Diagnosis included chronic obstructive pulmonary disease (COPD)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	χ (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
breathing with exertion, at rest and when lying admit/discharge report within the last 3	F 626	(A) Requires the seand (B) Is eligible for Me services or Medicainursing facility serv (ii) If the facility that who was transferrereturning to the facility, the facility in requirements of particles and distinct part. When returns is a compost 483.5), the resident of an available bed composite distinct previously. If a bed at the time of return availability of a bed at the time of return availability of a bed This REQUIREMENT by: Based on interview facility failed to reach hospitalization for 1 for discharge. Findings include: R147's discharge Medated 2/20/23, iden 2/20/23, with facility severe cognitive im chronic obstructive and R147 had shore	edicare skilled nursing facility dices. It determines that a resident divided with an expectation of lity, cannot return to the nust comply with the ragraph (c) as they apply to distinct part (as defined in the facility to which a resident site distinct part (as defined in the particular location of the part in which he or she resided is not available in that location in the resident must be given to that location upon the first there. Note that in the particular location in the resident must be given to that location upon the first there. Note that in the particular location in the resident must be given to that location upon the first there. Note that location upon the first there is not met as evidenced with and document review, the dimit residents after a of 1 resident (R147) reviewed. Minimum Data Set (MDS) tified R147 was discharged on which return anticipated. R147 had pairment. Diagnosis included pulmonary disease (COPD) thess of breath or trouble.		Cornerstone Nursing and Rehab of shall permit residents to return to the facility after hospitalization or there leave, unless specific exceptions a Facility Notice of Bed Hold and Respolicy was reviewed with no chang made. This policy addresses permoresidents to return to the facility and readmission to a composite distinct R147 expired prior to returning to the facility. An audit has been completed all current admissions, re-admissions, re-admissions, the facility	he peuticare met. turn es hitting det ted on one and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245307	B. WING _		09/	C 20/2023
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	1 03/	
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F 626	- 2/20/23 at 5:09 a. the emergency depmorning was admit - 2/22/23, R147's sreporting R147 may he wanted R147 to day. R147's son wawould not be able to 1:00 p.m. due to sta - 2/24/23 at 12:07 update from the horidentifying a decline plan was to discuss the resident 2/25/23 through 2 failed to identify confacility and hospital R147 hospital notes - 2/20/23, R147's e visit notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified 5:12 a.m. and was further care 2/25/23 at 10:00 progress notes identified at 10:00 progress notes identified and left a complete the call and left a voice transfer R147 back	otes identified the following: m., R147 was transferred to partment (ED) and later that ted to the hospital. son contacted the facility y be ready for discharge and return to the facility that same as told by facility staff they o readmit the resident after	F 62	residents were affected. Licensed nursing staff were educe the Notice of Bed Hold and Return and procedures on 10/10/23. Licensing staff not in attendance steeducated prior to the next sched A readmission checklist has bee and reviewed during education. The Director of Nursing or design complete audits on hospital transplant readmissions weekly for four we time every two weeks for one morandomly thereafter. Results shareviewed at QAPI to ensure command determine if additional monital necessary.	rn policy censed hall be uled shift. n created hee shall sfers and eks, one onth, and all be pliance	

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F 626	why R147 was not a 2/27/23 at 11:03, if update to the facility declining health star R147 to return to the On 9/19/23 at 3:34 attempted to reach was notified the omuntil 9/26/23. During interview on social worker (SW) transferred out of the responsible for obtaconsent for a bed haccept the resident medically stable. Staresident is readmeted to R147's progress manager called inquesident back to the unable to readmit donurse (RN) available. During interview on hospital case manar R147 was admitted On 2/22/253, R147 due to R147's declinospital talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked comfort care unable to readmit the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update on residents the hospital case mental talked with coordinate a care of update of talked with coordinate a care of update of talked with coordinate	ress notes failed to identify accepted for transfer. R147's son provided any regarding the residents tus. R147's family had wanted	F 6	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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F 626	facility agreed to are the resident when the would expect the face weekend. During interview or director of nursing was transferred to work with the hosp accommodate the readmission, including weekends. The face readmissions during is when the admitting over the allowed to die at Riccomfortable with he progress noted lace discharge and readmission of documentation in DON was unable to provided a good face reviewed 10/24/22, readmitted to the facility could in the facility could	Id for R147, which meant the ad could not refuse to readmit they were medically stable. CM acility to readmit even on a 19/20/23 at 12:27 p.m., the (DON) stated when a resident the hospital, the facility would ital case manager to residents needs and plans for ding readmissions on the cility was currently only taking ag the work week because that any nurses worked. R147 readmitted to the facility and ares in R147's home. By not e weekend R147 was not 147's home where she was er family nearby. R147's ked evidence of thorough dmission plans. Due of the lack in R147's progress notes the odetermine if the facility ith effort to readmit R147. Of Bed Hold Policy and Return identified a resident would be acility to the first available bed meet their needs.	F 6	526		
F 684 SS=D	received. Quality of Care CFR(s): 483.25 § 483.25 Quality of	cy was requested but not care fundamental principle that	F6	884		11/3/23
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			B) DATE SURVEY COMPLETED	
	245307	B. WING		09/20/2023		
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	D BE	(X5) COMPLETION DATE	
applies to all treatment facility residents. Be assessment of a rethat residents received accordance with proposed process. The complete accordance with proposed process, the complete accordance with proposed process. The complete accordance with proposed process, the complete by: Based on observative review, the facility frassessments for 2 and failed to provide directed for 1 of 2 mon-pressure related. Findings include: R148's entry Miniment 9/13/23, identified for gangrene (a comblood flow was cut causes tissues to be turns affected area left tow, osteomyelist, and extremity (foot) word of underlying osteon light of underlying os	nent and care provided to ased on the comprehensive esident, the facility must ensure every treatment and care in rofessional standards of rehensive person-centered residents' choices. Note in the facility must ensure every treatment and care in rofessional standards of rehensive person-centered residents' choices. Note in the facility on the fac	F 6	Cornerstone Nursing and Rehabeshall ensure wound assessments quality wound care are provided to residents. R21's wound was assest the Registered Nurse on 9/19/23, physician of condition and weekly monitoring was implemented. R14 discharged on 9/29/23. The facility administration history report was a for the previous 30 days on all resensure no others were affected. Initial skin assessments shall be completed on all new admissions wound assessment on newly ident wounds, by a licensed nurse. Raraudits shall be completed on all rewith dressing changes for complia reviewing the facility EMR administ history report weekly for 4 weeks, other week for 4 weeks, than rand thereafter. Licensed nursing staff were educated providing proper and timely wound as well as the need for initial and cassessments on 10/10/23. Licens nursing staff not in attendance shall	and our ssed by notified 48 was and a sified idents to a sidents noe by tration every omly ated on loare on-going ed all be		
			complete audits on wound assess	ments		
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa applies to all treatm facility residents. B assessment of a re that residents recei accordance with pr practice, the comple care plan, and the This REQUIREMEL by: Based on observa review, the facility fr assessments for 2 and failed to provide directed for 1 of 2 m non-pressure relate Findings include: R148's entry Minim 9/13/23, identified fr 9/13/23. R148's undated fact of gangrene (a con blood flow was cut causes tissues to b turns affected area left tow, osteomyeli R148's hospital dis 9/13/23, identified fr osteomyelitis, and extremity (foot) wor of underlying osteo Identified wound or metatarsal (little to in or of bone) in the concerning for oste	ESTONE NSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	RECORRECTION 245307 B. WING. 245307 B. WING. PROVIDER OR SUPPLIER RESTONE NSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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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	STONE NSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) STATE AND OF CORRECTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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WIND 25TREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET MORTHEAST BAGLEY, MN 56621 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) 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 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, identified R64 admitted to the facility on 9/13/24, identified R64 admitted to 9/13/25, identified R64	

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F 684	osteomyelitis and g and required daily of -9/13/23 at 10:03 p. osteomyelitis and g addressed dressing -9/14/23 at 1:43 p.m wound progress not dressings?" -9/15/23 at 1:28 p.m wound progress not dressings?" -9/16/23 at 12:56 p. dressing, skin color -9/17/23 at 11:11 p. dressing to gangrer 9/18/23 at 2:35 p.m progress note comp. R148's medical rec wound/skin assessment was resulting an interview registered nurse (R are admitted with wone of the RN mansassessment within be charted in the primportance of the inbe to track any charmonitor for improve initial assessment able to find an initial chart and identified. On 9/20/23 at 11:00 dressing change for the state of the single to find an initial chart and identified.	m., R148 was hospitalized for angrene of 4th toe on left foot dressing changes to left foot. m., R148 was admitted for angrene of left food. Skin g change to left foot. n., "Wound? RN notified, te completed? Right foot, m., "Wound? RN notified, te completed? Left foot, m., "Dressings? Left foot/toe?" m., "Dressings? Left foot ne toes." n. "Wound? RN notified, wound oleted? Left foot, dressings?" ord lacked an initial ment. The initial wound/skin equested and not received. on 9/19/23 at 1:51 p.m., N)-A stated when residents rounds or dressing changes, agers would do a wound 20 hours of admit and it would rogress notes. The nitial wound assessment would need to the wound. RN-A was not all wound assessment in R148's it was not completed. of a.m., RN-B was completed a r R148. RN-B stated one of		four weeks, then every other we weeks, and randomly thereafter shall be reviewed at QAPI to en compliance and to determine if monitoring is necessary.	. Results sure	
	the nurse managers	s would do wound assessment				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 684	for the wound assechange and would RN-B could not find chart. RN-B continuate The dressing was released. The left fround concave area was intact and had color. The 4th toe wand toenail was reasome dark areas, at The 2nd toe had so toenail was intact. During an interview director of nursing a should be assessed. The importance of monitoring of the was not documented done and staff wou wound. R21's quarterly Min 7/11/23, identified so R21 was an extens hygiene. R21's progress note-9/12/23 at 10:43 as small open area on (adsorbent foam dressing applied 9/17/23 at 9:24 p.19/17/23 at 9:24 p.19/	24 hours of admit. The reason ssment was to watch for notify provider if getting worse. I a wound assessment in the led with the dressing change, emoved, and the left foot oot had a 1.5 centimeter (cm) a next to her little toe, the skin no drainage, but was gray in was black and was dried up ledy to fall off. The 3rd toe had and the toenail bed was black ome darker areas, but the con 9/20/23 at 1:58 p.m., the (DON) stated all wounds don admit or within 24 hours. The assessment was to ensure ound and identify any changes ening. If a wound assessment ed, she could not verify it was led not be able to monitor the limum Data Set (MDS) dated evere cognitive impairment, ive assist with personal e(s) identified the following: a.m., the bath aid reported left lower abdomenMepilex		584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 756	changed in three decremoved there was the dressing and in around wound communiter changed the R21's medical record the wound. The worequested and not R21's September Arecord (MAR) idented dressing changes was dressing changes was dressing's were sign completed daily 9/10. An interview with the and registered nurs 9/20/23 at 2:04 p.m. the wound was idented have been assessed chart lacked a would lower abdomen. The progress note on 9 dressing on R21's changed for three changes were ordered expected staff to as dressing changes at A wound/skin asses but none received. Drug Regimen Revenue.	14/23, and had not been ays. When the dressing was thick, purulent drainage on creased amount of redness pared to the last time the dressing on 9/13/23. Ind lacked an assessment of und assessment was received. Medication Administration of tified an order for daily was started on 9/12/23. The ned of as changed and 12/23 through 9/17/23 The director of nursing (DON) are (RN)-A was conducted on an DON and RN-A stated when notified on 9/13/23, it should and within 24 hrs and R21's and assessment for the left arey were both unaware of the 1/17/23, which identified the left lower abdomen was not days, when daily dressing ared. The DON stated she assess, monitor and do timely as ordered. The session of the left and the left lower abdomen was not days, when daily dressing ared. The DON stated she assess, monitor and do timely as ordered.	F 6			11/3/23	
SS=D	CFR(s): 483.45(c)(§483.45(c) Drug Ro §483.45(c)(1) The						

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F 756	Continued From pa	age 14	F 7	56			
	must be reviewed a licensed pharmacis	at least once a month by a st.					
	§483.45(c)(2) This of the resident's me	review must include a review edical chart.					
	irregularities to the facility's medical diractly and these reports resident (i) Irregularities incomply that meets the (d) of this section for (ii) Any irregularities during this review reseparate, written reattending physician director and director and director minimum, the resident and the irregularity (iii) The attending president's medical irregularity has been action has been taken to change in the	pharmacist must report any attending physician and the rector and director of nursing, must be acted upon. Clude, but are not limited to, any e criteria set forth in paragraph or an unnecessary drug. It is noted by the pharmacist must be documented on a sport that is sent to the limited and the facility's medical or of nursing and lists, at a lent's name, the relevant drug, the pharmacist identified on reviewed and what, if any, is cen to address it. If there is to be medication, the attending ocument his or her rationale in cal record.					
	maintain policies and drug regimen review limited to, time franthe process and stewhen he or she ide requires urgent act. This REQUIREMENT.	facility must develop and nd procedures for the monthly w that include, but are not nes for the different steps in eps the pharmacist must take intifies an irregularity that ion to protect the resident. NT is not met as evidenced					
		v and document review the ure pharmacy consultants		Cornerstone Nursing and Reshall ensure all resident druc			

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F 756	Continued From pa	ige 15	F 7	56		
		were followed up on in a timely esidents (R29, R32) reviewed agement.		are reviewed at least once a licensed pharmacist and following a timely manner. R32 famous was discontinued on 9/20/23 trazodone 50mg was discontinued on 9/20/23	lowed up on in tidine 20mg 3 and R29	
	R29's quarterly Min 8/4/23, identified R2 impairment with dia dementia, and Hun inherited disease th	•		Additional Registered Nurse given access to the pharma retrieve drug regimen pharmand ensure follow up is combined timely manner. Nursing shall audit on all residents who reanti-depressants and PPIs it days, by using the order by report to check for similarities.	es have been acy portal to nacy reviews all perform an eceived in the last 30 category	
	Review Physician F 3/23/23, identified F antidepressant and tablets. The Center Services (CMS) recognized psychotropic (mediaddressed as soon 60 days. R29's mesigned off on the C Medication Review days after recommonly addressed after information. The present and tablets and tablets are commonly addressed after information. The present and tablets are commonly addressed after information. The present and tablets are commonly addressed after information.	charmacist's Medication Recommendation dated R29 received trazodone (and sedative) 50 milligram (mg) rs for Medicare and Medicaid quired evaluation of cations which affect a person's cations. This was to be as possible but no later than edical provider reviewed and consulting Pharmacist on 9/20/23. It was over 180 endation was given and was er the surveyor requested the covider noted "drug d/c ady" and was rejected but did it happened.		notify the physician of any ir Drug Regimen education are has been completed by Reg Nurses responsible for review through on pharmacy recommendation of Nursing or described the monthly pharmacy summary report for 3 months ensure all recommendations addressed in a timely mann shall be reviewed at QAPI to compliance and to determine monitoring is necessary.	regularities. Ind post-test gistered ew and follow nmendations. designee shall cy review as to audit and s are er. Results o ensure	
	director of nursing of time where the factor of nursing of time where the factor of th	on 9/20/23 at 1:27 p.m., the (DON) stated there as a period acility did not received any cist's Medication Reviews portal and some may have facility did not call the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245307	B. WING		0:	C 9/ 20/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (416 SEVENTH STREET NORTHEAS BAGLEY, MN 56621	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 756	The medication revaluation revaluation and ressed within the ensure residents within the medications. The medications is a second or sec	age 16 st the medication reviews. views would be expected to be ne stated time periods to vere not receiving unnecessary nedication review from ddressed until 9/20/23, after	F 7	756			
	had diagnoses that hypertension, bipole utilized antipsychot anticoagulant medical R32's Consulting Provider Review Recommendational R32 recessoretion reducer) suggested to either (only if appropriate rationale) why the crisks to stay on the provider reviewed a Consulting Pharma 1/18/23, and noted R32's Consulting Pharmacist suggested reduction (only if an (with clinical rational outweighed the risk outweighed	Pharmacist's Medication andation dated 1/18/23, ived famotidine (a gastric acid 20 mg tablets. The pharmacist consider a dose reduction or to document (with clinical current benefits outweighed the current dose. R32's medical and signed off on the acist Mediation Review dated "pros greater than cons." Pharmacist's Medication andation dated 2/21/23,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		245307	B. WING		06	C / 20/2023
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 416 SEVENTH STREET NORTHEA BAGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 756	recommendation after the State Ag information. The particle of	was given and only addressed ency (SA) requested the provider noted "patient still lue." Pharmacist's Medication endation dated 3/28/23, eived famotidine (a gastric acid) 20 mg tablets and omeprazole cretion reducer and proton Pl)) 20 mg delayed release (DR) farmacist identified R32 both mediation and acid be adequately suppressed with the pharmacist suggested to sing the ongoing need for both I consider discontinuing one of f possible. R32's medical and signed off on the facist Medication review dated sover 180 days after the was given and only addressed ency (SA) requested the provider noted "discontinue"		756		

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F 756	get access for a "c	age 18 because the facility did not ouple" of months. Review of irmacist's Medication Review	F 7	756		
	Recommendations important because	in a timely manner was it could potentially lead to the y medication or a medication				
	p.m., pharmacist-B were reviewed more generated for the fathe role in May 202 all recommendation the same pharmacist-B were sent to the father recommendation, in the report was forwalf there were no recommendations. The world list the review pharmacist-B would report to determine responded to. If no the recommendation within 60 days. The was to help the number requirements. Pharmacist-B would recommendations provide assistance requirements. Pharmacist-B	stated all active residents at thly and reports were acility. Pharmacist-B took over 3; however, was able to review as prior to that because it was y system. Once the reports cility, if there was a nursing might take care of it or varded to the medical provider. commendations, the report w as such. Typically, d review the prior month's if all recommendations were t, pharmacist-B would resend on so it would be addressed a consultant pharmacist role sees to ensure all were responded to and to to staff to meet regulation macist-B stated the facility bility to access the portal and				
	had assisted the farecommendations within 60 days. The facility policy F dated 11/14/22, idea review periodically were still necessariant.	cility to gain access. Yes, the should have been addressed harmacy Services Overview entified the physician would whether current medications y in their current doses; for an individual's conditions or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	· /	X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	
CORNER	STONE NSG & REHA	AB CENTER		416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	•	
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F 756	Continued From pa	ge 19	F 7	' 56		
F 757 SS=D	enduring that they recontinue the current conditions and risks well managed or comedications, or with policy failed to identication pharmacist's role not consulting Pharmacist Recommendation services.	or the timeframe when a cist's Medication Review hould be addressed. Tee from Unnecessary Drugs	F 7	757		11/3/23
	Each resident's drugs unnecessary drugs drug when used-	ssary Drugs-General. g regimen must be free from . An unnecessary drug is any cessive dose (including apy); or				
	§483.45(d)(2) For e	excessive duration; or				
	§483.45(d)(3) With	out adequate monitoring; or				
	§483.45(d)(4) Withouse; or	out adequate indications for its				
	. , , ,	e presence of adverse th indicate the dose should be nued; or				
	stated in paragraph section.	combinations of the reasons s (d)(1) through (5) of this				
	by:	NT is not met as evidenced				
		and document review, the		Cornerstone Nursing and R	ehab Center	

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 416 SEVENTH STREET NORTHEAS BAGLEY, MN 56621			
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F 757	was evaluated for of 5 residents (R3 for use for antibio reviewed for unnersidence). R32's annual MD had diagnoses the failed to identify if reflux disease (G disease where the refluxes into the extremely the mouth and stored (R32's Physician (r necessity by the physician for 2 (32); failed to obtain justification tics for 1 of 5 residents (R2) ecessary medication. S dated 7/24/23, identified R32 at included dementia. The MDS (R32 had gastroesophageal ERD) (A chronic digestive e liquid content of the stomach esophagus, the tube connecting omach) or ulcer. Order Report dated 7/28/23 -	F 7	shall ensure each resident's is free from unnecessary drevaluation by the physician famotidine was discontinue and R2 has an appointment 11/15/23 to see urology to a prophylactic antibiotic usage A 72-hour antibiotic timeout been implemented for all reare prescribed an antibiotic perform audits on current repast 30 days, for ABX, PRN PPIs using order by catego check for similarities for 4 wnotify the physician of any in Additional Registered Nurse given access to the pharma retrieve drug regimen pharmand ensure follow up is contimely manner for all reside Drug Regimen education and has been completed by Reg Nurses responsible for reviethrough on pharmacy recont The Director of Nursing or audit the monthly pharmacy summary report for 3 month recommendations are addratimely manner. Facility Infection Prevention shall monitor antibiotic usage a week for two weeks, then weeks and randomly therea shall be reviewed to ensure timeout form is completed to faxed to MD. Results shall QAPI to ensure compliance determine if additional monnecessary.	rugs through . R32 d on 9/20/23 t scheduled on address e. form has esidents who a Nursing shall esidents for the NABX, and ry report to weeks and rregularities. es have been acy portal to macy reviews apleted in a nt reviews. Independent of the NABA and follow and		

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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F 757	recommendation waster the State Age information. The profession of	r 180 days after the ras given and only addressed ncy (SA) requested the rovider noted "discontinue e omeprazole". on 9/20/23 at 1:23 p.m., the (DON) stated she was applicate medication until that Consulting Pharmacist's Recommendation forms were any The Consultant cation Review in a timely manner was it could potentially lead to the y medication or a medication ald have reviewed R32's assessments and contacted	F 7	57		
	9/5/23, identified Rahad a suprapubic of included multiple so bladder. R2 had tall during the assessment A/5/23, identified Rahad UTI and took a single	mum Data Set (MDS) dated 2 was cognitively intact and atheter. R2's diagnoses clerosis and neurogenic ken an antibiotic one time nent period. Area Assessment (CAA) dated 2 had no signs or symptoms of gle day a week, rotating ylactic urinary tract infection				
	R2's care plan revis	sed 9/13/23, identified R2 had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 757	Continued From pa	ge 22	F 7	757			
	monitor and report	status and directed staff to signs and symptoms of UTI ls, bladder spasms, and					
	identified R2 was p antibiotics on 7/15/2 - ciprofloxacin HCL	rs report dated 7/6/23, rescribed the following 22, for UTI: 500 mg tablet take one tablet ay on the 1st Monday of the					
	capsule by mouth of the month.	te 100 mg capsule take one once a day on the 2nd Monday					
	tablet once a day of month cephalexin 500 m	vulanate 875-125 mg take one n the 3rd Monday of the grapsule take one capsule by on the 4th Monday of the					
	(MMR) dated 9/18/2 suggested R2's door of the antibiotic's (a effectiveness would	dication monitoring review 22, identified the pharmacist ctor re-assess the ongoing use It the current dose I be questionable and the risk four antibiotics maybe					
	increased) for chromodynamics increased request pharmacist request current benefits out medical doctor (MD stated R2's urologis	nic UTI prophylaxis. The ed a clinical rationale if the weighed the risks. The elected the suggestion and st recommended the resident					
		the antibiotics. The MMR en the antibiotics had been urologist.					
	- On 9/15/23, 7/6/23	s identified the following: 3, 2/2/23, 12/8/22, 10/13/22, as seen by the medical doctor					

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		245307	B. WING			09/20/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (416 SEVENTH STREET NORTHEAS BAGLEY, MN 56621			
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F 757	(MD) on rounds. Tantibiotics R2 was - On 6/28/23, 4/17/MDS assessment single day a week, prophylactic UTI. During interview or licensed practical redifferent antibiotic Monday's of each reduced urologist prescribe was prone to UTI's a long time. During interview or medical doctor state past and the urologist prescribe was prone to UTI's a long time. R2's urology visit no requested and not provide documentations were being reviewed justification for prophylactic regimentations. The December of the pharmacist and admission. The December of the pharmacist and admission. Inapprote to organisms being the pharmacist and admission. Inapprote to organisms being the pharmacist and admission.	he notes failed to identify if the taking had been addressed. (23, 3/10/23, and 1/4/23, the notes identified R2 took a rotating, antibiotic for a 9/20/23 at 10:47 a.m., hurse (LPN)-A stated R2 took a every Monday for the first four month. LPN-A thought the did the antibiotics because R2 and had been taking them for a 9/20/23 at 2:19 p.m., R2's ted R2 had multiple UTI's in the gist wanted R2 to continue on the last year were received. The facility failed to ation that R2's medications and by a urologist and there was phylactic antibiotic use. In 9/20/23 at 1:01 p.m., the sadmitted on 7/15/22, and biotic regimen prior to ON thought the medications on admission but was uncertain viewed since that time. R2's should have been reviewed by the doctor since R2's opriate antibiotic use could lead gresistant the antibiotics used,		757			
	,	of antibiotics available for use tially be harmful to R2 and					

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CORNER	STONE NSG & REHA	AB CENTER		BAGLEY, MN 56621			
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F 757	The facility policy P dated 11/14/22, idea review periodically were still necessary example, whether a risk factors were su enduring that they recontinue the current conditions and risks	d could cause R2 to receive otics. harmacy Services Overview ntified the physician would whether current medications in their current doses; for an individual's conditions or efficiently prominent or equire medication therapy to t dose, or whether those is could potentially be equally entrolled without certain	F 7	757			
	Free from Unnec Pace CFR(s): 483.45(c) (3) §483.45(c) (3) A psy affects brain activiting processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compression	sychotropic Meds/PRN Use 3)(e)(1)-(5) cropic Drugs. chotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following		758		11/3/23	
	§483.45(e)(1) Residently sychotropic drugs unless the medication as in the clinical record	must ensure that—dents who have not used are not given these drugs on is necessary to treat a diagnosed and documented					

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F 758	Continued From pa	age 25	F 7	58			
	behavioral interver	ual dose reductions, and tions, unless clinically an effort to discontinue these					
	§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						
	are limited to 14 days, he sationale in the res	I orders for psychotropic drugs ays. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their ident's medical record and on for the PRN order.					
	drugs are limited to renewed unless the prescribing practition the appropriatenes. This REQUIREME	I orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced					
	facility failed to ensimedication had a complysician for contingents reviewed medications. Findings include: R32's annual MDS	dated 7/24/23, identified R32 included dementia, bipolar		Cornerstone Nursing and Reh shall ensure each resident's dris free from unnecessary psychology. R32's primary care phyreviewed and signed the pharm recommendation stating residence continue dosage. R32 has been being seen by a psychiatric propassist in managing appropriate psychotropic medications. Additional Registered Nurses has given access to the pharmacy	ug regimen notropic sician nacy nt to n and is vider to		

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPROPRIES (DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 758	Assessment (CAA continued to take a adverse effects. R3 current. R32's Consulting P Review Recommer identified R32 receivantidepressant) 20 CMS required evaluation. The phaconsider a dose receivation document (with a current benefits out the current dose. Rareviewed and signed Pharmacist Medical over 180 days after given and only add (SA) requested the noted the recommendation.	dication. drug use Care Area) dated 7/24/23, identified R32 ntidepressant without any 2's care plan remained harmacist's Medication ndation dated 2/21/23, ived fluoxetine (an milligrams (mg) capsules. uation of psychotropic armacist suggested to either duction (only if appropriate) or clinical rationale) why the tweighed the risks to stay on 32's medical provider ed off on the Consulting tion review on 9/20/23. It was the recommendation was ressed after the State Agency information. The provider endation for gradual dose	F 7		ted in a ted in a ted in a ted in a ted shall be all cesidents ensure ed Nurses hotropic ed on ropic ll be npliance		
	R32's physician prothrough 8/29/23, far fluoxetine use. During a interview of director or nursing unaware of the Core Medication Review rational for the use requested the Consequested the Consequence of th	cted" and "patient still e." ogress notes dated 9/20/23 iled to identify the rationale for on 9/20/23 at 1:23 p.m., the (DON) stated she was nsulting Pharmacist's Recommendation to obtain a of fluoxetine until the SA sulting Pharmacist's Recommendations. The ultant Pharmacist's Medication					

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CO 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
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F 758	was important bec	age 27 ndations in a timely manner ause it could potentially lead to ssary medication or a	F 7	758			
F 881 SS=D	dated 11/14/22, ide review periodically were still necessar example, whether risk factors were s enduring that they continue the curre conditions and risk	ship Program	F 8	381		11/3/23	
	program. The facility must e	on prevention and control stablish an infection prevention m (IPCP) that must include, at llowing elements:					
	that includes antibes system to monitor. This REQUIREMED by: Based on interview facility failed to est review in order to the state of	NT is not met as evidenced wand document review the ablish a process for antibiotic determine appropriate sistance for use of an antibiotic		Cornerstone Nursing and Reinfection prevention and confushall include an antibiotic steprogram that includes antibiotic protocols and a system to mantibiotic use. R12 completed Augmentin 8 on 7/24/23 and was seen by	trol program wardship otic use onitor 75mg-125mg		

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PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
8/25/23, identified Fincluded anxiety, reobstructive pulmun hyperlipidemia (high not identify R12 util R12's Physician Or 6/30/23-7/31-23, id 5/31/23 - 6/7/23, a clavulanate 875-12 mouth twice a day. 7/14/23 - 7/24/23, clavulanate 875-12 mouth twice a day. R12's nursing prog following: -6/27/23 at 1:51 p.r provider on rounds lower extremity swe on three courses of bacterial skin infect to see how R12 did 7/14/23 at 9:52 a. provider regarding and thigh as well as received orders for mouth twice a day 7/17/23 at 3:22 p. R12's provider regardiscuss the possibil blood clot. A messanurse to return call.	simal Data Set (MDS) dated R12 had diagnoses that espiratory failure, chronic ary disease (COPD) and h cholesterol). The MDS didized antibiotics. Ider Report dated entified the following: amoxicillin potassium 5 miligram (mg) 1 tablet by amoxicillin potassium 5 miligram (mg) 1 tablet by ress notes identified the m., R12 was seen by his The provider evaluated R12's elling and redness. R12 was fantibiotics for cellulities (a tion) and his provider wanted without antibiotics. m., a call was placed to R12's R12's increased redness in leg as swelling and pain. Nursing Augmentin 875-125mg by for 10 days. m., nursing attempted to call arding R12's lower extremity to lity of an ultrasound rule out age was left for R12's clinic	F 8	physician on 8/1/23 stating RLE w to baseline. R2 has an appointment scheduled on 11/15/23 to see uroly address prophylactic antibiotic usate. The Director of Nursing or designer perform audit on current residents last 30 days, for ABX and PRN AB order by category report to check similarities to ensure no other residents who are prescribed an attended by a licensed staff shall be educated on utilization and follow-up of 72-hour out form. Infection Preventionist meducated on antibiotic stewardship facility Infection Preventionist or shall monitor antibiotic usage threat week for two weeks, then week weeks and randomly thereafter. As shall be reviewed to ensure 72-hour out form is completed timely form the mouter of the previewed at ensure compliance and to determine additional monitoring is necessary.	nt ogy to oge. e shall for the X using for dents time out in time or time or two outs or axed to QAPI to ne if		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245307	B. WING		09	C /20/2023	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	DE	7_0,_0_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 881	director of nursing resident was starte instance, a UTI, nu culture to ensure the antibiotics. Nursing that. Ideally, nursing would be sent to the why the antibiotic waneeded to be reass should be stopped. antibiotic review in too much to do and R12 had been on nuch to do and R12 had been on nuch to determined what we with antibiotics to si	on 9/20/23 at 10:18 a.m., the (DON) stated ideally when a d on an antibiotic, like for rsing requested to get a urine the bacteria was sensitive to tried to follow through with g would complete a form that the resident's provider to show was needed, if the antibiotic are seed and/or if the antibiotic are long time because she had it was put on the back burner. The part of the back burner and it was never really as wrong. R12 was treated the if it would help, but the las just R12's "baseline."		381			
	9/5/23, identified dia (MS), neurogenic be catheter in place. Retime during the assemble R2's physician ordered identified R2 was plantibiotics on 7/15/2 (UTI): - ciprofloxacin HCL by mouth once a damonth. - doxycycline hyclaticapsule by mouth of the month.	num Data Set (MDS) dated agnoses of multiple sclerosis ladder, and had a suprapubic 2 had taken antibiotics one essment period. er report dated 7/6/23, rescribed the following 22, for urinary tract infection 500 mg tablet take one tablet ay on the 1st Monday of the te 100 mg capsule take one once a day on the 2nd Monday vulanate 875-125 mg take one					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	, , ,	TE SURVEY MPLETED
		245307	B. WING		09	C / 20/2023
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 881	tablet once a day of month. - cephalexin 500 m mouth once a day of month. R2's progress note - 9/15/23, 7/6/23, 2 9/15/22, R2 was see on rounds. The not antibiotics R2 was - 6/28/23, 4/17/23, assessment notes a week, rotating, and was taking the admitted to the facinand was taking the admitted. LPN-A the was ordered by the where the order orion to admission. The facility and providing antibiotic of the pharmacist show antibiotic and providing propriate use of resistant organisms antibiotics the residue to R2 of The facility Antibiotics.	g capsule take one capsule by on the 4th Monday of the sidentified the following: /2/23, 12/8/22, 10/13/22, and en by the medical doctor (MD) es failed to identify if the taking had been addressed. 3/10/23, and 1/4/23, the MDS identified R2 took a single day intibiotic for prophylactic UTI. 9/20/23 at 10:47 a.m., urse (LPN)-A stated R2 was lity on 7/15/22. R2 had UTI's antibiotic cycle prior to being hought R2's antibiotic cycle urologist but was uncertain ginally came from. 9/20/23 at 1:01 p.m., the (DON) stated R2 was admitted s taking a one day per week, ycle for a very long time prior DON was unable to identify a were originally prescribed or 2's admission, the doctor and all have addressed R2's ded a rationale for use. Of antibiotics could lead to s which could limit the lent could use and potentially	F 8	81		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	` '	E SURVEY IPLETED
		245307	B. WING _		09/	20/2023
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	_ -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 883	staff expectations to system to ensure reappropriate antibiotic events and strive for include a system for resident outcomes organisms or negative directed the IP to the type, dose, duration appropriate diagnost adherence to evide documenation relative, tracking antibipatterns/trends of the antibiotic steward for clinical outcome antibiotic resistant of Influenza and Pneu CFR(s): 483.80(d) (1) Influenza and proceed (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octobannually, unless the contraindicated or formunized during the immunized during the contraindicated or formunized during the contraindicated or formunized during the immunized during the opportunity (iv) The resident's necessary and the opportunity (iv	ain guidelines about facility o develop and implement a residents received the stics, reduce risk/adverse or quality outcomes, this would be monitoring to improve and reduce antibiotic resistant tive outcomes. The procedure rack antibiotic use including an prescribing practitioner, and sis. The IP would also monitor recebased criteria including: the to antibiotic selection and otics used to review use and determine impact of ordship interventions, monitor residents and C-diff. Improced Immunizations (1)(2) The facility must develop the further to ensure that he influenza immunization, regarding the benefits and the of the immunization; offered an influenza ber 1 through March 31 re immunization is medically the resident has already been	F 88			11/3/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245307	B. WING _		09/20/2023
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	O BE COMPLETION
F 883	was provided educated and potential side of immunization; and (B) That the resider immunization or didition or didition immunization due to refusal. §483.80(d)(2) Pneumust develop policit that— (i) Before offering the immunization, each representative receive benefits and potent immunization; (ii) Each resident is immunization, unless that the opportunity (iv) The resident or has the opportunity (iv) That the resident was provided educated and potential side of immunization; and (B) That the resider pneumococcal immunization or other immunication or ot	Int or resident's representative ation regarding the benefits effects of influenza and either received the influenza and not receive the influenza of medical contraindications or a mococcal disease. The facility designed and procedures to ensure the pneumococcal aresident or the resident's eives education regarding the eital side effects of the facility offered a pneumococcal as the immunization is licated or the resident has enized; the resident's representative to refuse immunization; and medical record includes a indicates, at a minimum, the ent or resident's representative ation regarding the benefits effects of pneumococcal and either received the munization or did not receive immunization due to medical	F 88	33	
		v and document review, the vide the most recent Centers		Cornerstone Nursing and Rehab of strives to ensure each resident is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	` ′	E SURVEY IPLETED
		245307	B. WING			C 20/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 883	the potential risks a pneumococcal vace R16, R32, R37, R4 Findings include: R2's quarterly Mining 9/5/23, identified R2 on 7/15/22, was 74 that included hyper multiple sclerosis (IR2's undated, Previmmunization recompresentative reception and the previous significant characteristic previous	I (CDC) education regarding and benefits of the cine for 5 of 5 residents (R2, 0) reviewed for immunizations. mum Data Set (MDS) dated 2 was admitted to the facility years old and had diagnoses tension, renal failure, and MS). The entative Health Care and the PCV13 on 9/16/16. Include evidence R2 or R2's eived education regarding cine booster and there was no offered the pneumococcal uidance. The ange MDS dated 8/22/23, admitted to the facility on ars old. The entative Health Care and there was noted identified R16 refused cination due to "conscientious er, R16's EHR did not include 16's representative received geneumococcal vaccine. The dated 7/24/23, identified R32 and facility on 8/16/22, was 78 diagnoses that included tementia.	F 8	the appropriate information for rethe Influenza and Pneumococca vaccines. R2, R16, R32, R37, and R40 has offered pneumonia vaccine and education regarding the potentia and benefits of the vaccines. Aucompleted on current residents for pneumococcal and flu vaccination eligible residents were offered the and has been documented. Lice shall be educated on CDC guide vaccines. Vaccine Information S and consent form have been added admission packet to ensure all referred and educated on vaccine in the Director of Nursing or design complete audits on all new admission packet for four weeks, then ever week for four weeks and random thereafter to ensure influenza and pneumococcal immunizations are information is offered and docum. Results shall be reviewed at QAI ensure compliance and determinadditional monitoring is necessal.	re been provided risks dit was or ons, all e vaccine shall sidents cines. The shall sidents of the sidents of t	
	R32's undated. Pre	ventative Health Care				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	` '	ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	DE	JI LUI LULU
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 883	PCV13 on 10/27/14 evidence R32 or R3 education regarding booster and there woffered the pneumoguidance. R37's quarterly Min 9/8/23, identified R3 3/27/23, was 61 year included non-traum diabetes and deme R37's undated Previmmunization recorreceived a pneumodid not include evid representative recepneumococcal vaccine per CDC grandication R37 was vaccine per CDC grandication R37 was vaccine per CDC grandication R40's significant chidentified R40 was 6/23/23, was 76 year included anemia, mobstructive pulmonated R40's undated, Presimmunization recorreceived the PCV13 not include evidence received education vaccine booster and was offered the pneumoguidance.	d, identified R32 received the R32's EHR did not include 32's representative received preumococcal vaccine was no indication R32 was accoccal vaccine per CDC imum Data Set (MDS) dated 37 was admitted to the facility ars old and had diagnoses that actic brain dysfunction, ntia. Ventative Health Care d, failed to identify if R37 coccal vaccine. R37's EHR ence R37 or R37's ived education regarding cine and there was no offered the pneumococcal		883		
	Daning interview on	5/ 15/25 at 5.25 μ.m.,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	ATE SURVEY OMPLETED
		245307	B. WING		C	C 9/20/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 416 SEVENTH STREET NORTHEAS BAGLEY, MN 56621	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 883	was admitted, nurs medical record for was not up to date, immunizations. RN administered a pnefacility and was unavaccine guidance. During an interview director of nursing of updated pneumo pharmacy sent a list pneumococcal vac schedule a vaccine to administer all netime; however, staffinfluenza vaccines pneumococcal vaccimmunization chec but had not implement the facility policy P10/17/22, identified would be assessed pneumococcal vaccines within thir medically contrained for the pneumococcal vaccines within the pneumococcal v	age 35 RN)-A stated when a resident ing reviewed the resident's immunizations. If the resident the facility offered the -A had never offered nor sumococcal vaccine at the aware of pneumococcal on 9/20/23 at 10:40 a.m., the (DON) stated she was aware occal guidelines and the st of residents who qualified for cination. The DON wanted to coccal guidelines at the same of began administering but had not offered cines yet. The DON created an klist for a resident's admission mented the checklist yet. Incumococcal Vaccine revised upon admission, residents of the pneumococcal ty days of admission unless licated. Before receiving either cal vaccines, the resident or expected was requested but not the Pneumococcal Vaccine was requested but not		383		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	ULTIPLE CONSTRUCTION _DING		ATE SURVEY OMPLETED
		245307	B. WING		00	C 9/ 20/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	JI LUI LULU
CODNED	STONE NSG & REHA	AR CENTED		416 SEVENTH STREET NORTHEAST		
CORNER	STONE NOO & REITE	AD CLIVILIC		BAGLEY, MN 56621		
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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 <u>only a suggestion</u> 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.

Cornerstone Nsg & Rehab Center October 4, 2023 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.

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

Minnesota Department of Health

Kumala Fiske Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
	00974	B. WING		C 09/20/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
CORNERSTONE NSG & REHA	AB CENTER	NTH STREE MN 56621	T NORTHEAST	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED T	D BE COMPLETE
2 000 Initial Comments		2 000		
****ATTEN	NTION*****			
NH LICENSING	CORRECTION ORDER			
144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall with a schedule of function the Minnesota Department of which corrected requires of the number and MN Rule When a rule contain comply with any of the pursuant to a surver found that the deficit herein are not corrected shall be with a schedule of function of which are not sometimes of the number and MN Rule when a rule contains comply with any of the pursuant to a surver found that the deficit herein are not corrected shall be with a schedule of function and the survey for the number and many of the survey for the pursuant for the pursuant for the survey for the pursuant for the survey for the pursuant for the pursuant for the survey for the pursuant for the pursuan	nether a violation has been			
re-inspection with a result in the assess	ny item of multi-part rule will ment of a fine even if the item iring the initial inspection was			
that may result from orders provided that the Department with	hearing on any assessments non-compliance with these ta written request is made to nin 15 days of receipt of a nt for non-compliance.			
was conducted at yethe Minnesota Department of the Minneso	S: 9/20/23, a licensing survey our facility by surveyors from artment of Health (MDH). Your compliance with the MN State ollowing correction orders are cate in your electronic plan of reviewed these orders and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Electronically Signed

10/13/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00974	B. WING			0/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CORNE	RSTONE NSG & REHA	AB CENTER	NTH STREE MN 56621	T NORTHEAST		
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2 000	Continued From pa	ge 1	2 000			
	identify the date wh	en they will be completed.				
	H53075593C (MN9	laint(s) were reviewed: 5998) with no licensing orders (MN91452) with a licensing 8.0135 Subp. 1.				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The appears in the far leading." The state state listed in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For	correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rection.				
	receipt of State lice the Minnesota Department of Heal you electronically. is necessary for State enter the word "corr text. You must then State licensure proc completion date, the	in state.mn.us/facilities/regulation_1.html The State licensing ed on the attached Minnesota on the attached Minnesota of the orders being submitted to although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the				

Minnesota Department of Health

STATE FORM 6899 6DTP11 If continuation sheet 2 of 23

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C		, ,	E CONSTRUCTION	COMP	LETED
		00974		B. WING		09/2) 20/2023
NAME OF F	PROVIDER OR SUPPLIER	S1	TREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
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2 000	Continued From pa	ge 2		2 000			
2 265	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREME CORRECTION FOR MINNESOTA STAT	N OF CORRECTION." RAL DEFICIENCIES OF CONTROL THE CONTROL THE CONTROL THE CONTROL TO SUBMIT A PLA	THIS NLY. HERE	2 265			10/20/23
2 200	Resident Health Sta	•		2 200			10/20/23
	policies to guide star physicians, physician practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	st develop and implement of decisions to consult an assistants, and nurse known, notify the residence or an interested family at a minimum, the director of the medical director of must be involved in the se policies. The policies address at least the tion times for:	e ent's us ctor of or an				
		nvolving the resident when has the potential for recon;					
	physical, mental, o example, a deterior	change in the resident's resident's respectively the resident's ation in health, mental, in either life-threatening loomplications;	or or				
	example, a need to	er treatment significant discontinue an existing adverse consequences f treatment;	form				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
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		00974	B. WING		09/20/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	
CORNER	RSTONE NSG & REHA	AB CENTER	/ENTH STREE Y, MN 56621	ET NORTHEAST	
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2 265	Continued From pa	ge 3	2 265		
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or			
	E. expected an	d unexpected resident death	5.		
	This MN Requirements	ent is not met as evidenced			
	facility failed to informedication error for	and document review, the rm the physician of a 1 of 5 residents ecessary medications.		corrected	
	Findings include:				
		num Data Set (MDS) dated diagnosis of hypertension.			
	R32 was to receive	ler dated 8/17/22, identified amlodipine (a blood pressure rams (mg) by mouth every	9		
	9/1/23 through 9/20 - On 9/1/23, R32 wa	dministration History dated /23, identified the following: as not administered medication was not there,			
	- On 9/2/23, R32 was amlodipine due to " - On 9/3/23, R32 was	as not administered			
	amlodipine due to "	as not administered unavailable".			
	amlodipine due to "	as not administered unavailable". as not administered			
	amlodipine due to " - On 9/7/23, R32 wa	unavailable". as not administered			

Minnesota Department of Health

STATE FORM 6899 6DTP11 If continuation sheet 4 of 23

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	, ,		ATE SURVEY OMPLETED	
		00974	B. WING			C 20/2023	
	PROVIDER OR SUPPLIER	AB CENTER 416 SE	ADDRESS, CITY, S VENTH STREE Y, MN 56621	TATE, ZIP CODE T NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 265	amlodipine due to " On 9/9/23, R32 wa amlodipine due to " On 9/10/23, R32's On 9/11/23,R32 wa amlodipine due to " R32's nursing programmedication card was pharmacy was called deliver the medication was misting the repeated medication was misting the rest of the cart of the wrong area, the to make sure it was delivery. If the medication or if the physician would call the delivered. If the pharmedication or if the physician would be steps. Physician no because, ultimately all medications and care. For example a vitamin may not be blood pressure medication or recall if she had R32's physician.	unavailable". as not administered unavailable". as not administered unavailable". amlodipine was administere as not administered unavailable". ress note dated 9/11/23 at ad R32's amlodipine as missing since 9/10/23. The ad and the pharmacy would ion that evening. The note R32's physician was notified o	f d. d., ee				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00974	B. WING			C 20/2023
	PROVIDER OR SUPPLIER	AB CENTER 416 SEVE	, ,	STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 265	expect nursing to passessment when a notify the pharmacy and to notify the resiguidance. In addition expected to fill out a was submitted to the DON stated was unamlodipine and was medication error for During a telephone a.m., pharmacist-A a call from the facilit R32's amlodipine. It was delivered on 8/ used 9/1/23-9/14/23 normally, the facility found. The pharmathrough all the delivering missed but would do same day. Amlodipicause an elevated potentially lead to a such as stroke. During a telephone p.m., R32's physician would contain the never had this heap expect nursing to contain the never had this heap expect nursing to contain the never had this heap expect nursing to contain the never had the physician would contain the never had the heap expect nursing to contain the never had the heap expect nursing the never had the heap expect nursing the never had the never had the never had the never had the	(DON) stated she would erform a full resident a medication error occurred, of the needed medication, sident's physician to request on, the nursing staff were a medication error form which he DON for investigation. The naware of R32's missing sunable to locate a completed				

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	AND BLAN OF CORRECTION IN TOENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00974	B. WING			C 20/2022	
		00974			09/2	20/2023	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CORNER	RSTONE NSG & REHA	AB CENTER	ENTH STREE , MN 56621	T NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 265	5 Continued From page 6		2 265				
	revised 8/24/22, ide was to be reported DON or charge nurse would take proper a safety of the resider immediately notify the finding the medication able, and fill out the file with the DON. It made by the person Medication Error Fordesignated by the Eindividual who made	ledication Error Reporting entified the medication error immediately when noted to the se. The DON or charge nuse action and steps to ensure the nt and assess need to he physician. The person on error would correct, when Medication Error Form and Documentation was to be a finding the error in the form. The DON or as DON shall review with the e the error and provide as to prevent further errors.					
	The DON or design medication error protection to the medical proving regarding the timely provider; then audit	HOD OF CORRECTION: lee could review and revise actices to include notification ider; inservice nursing staff notification of the medical to ensure compliance. R CORRECTION: Twenty-one					
	(21) days.						
2 340	MN Rule 4658.0135	5 Subp. 1,2 Policy Records	2 340			10/20/23	
	procedures directly adopted by the hombe be made available to	lity of policies. All policies and related to resident care ne must be placed on file and upon request to nursing homes, legal representatives, and ntatives.					
	policies must be ma	sion policies. Admission ade available upon request to its, family members, legal					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		00974	B. WING		C 09/20/2023
NIAME OF I	PROVIDER OR SUPPLIER		ADDRESS CITY	STATE, ZIP CODE	OUIZOZO
		416 SE	, ,	ET NORTHEAST	
CORNER	RSTONE NSG & REHA	AB CENTER	Y, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 340	Continued From pa	ge 7	2 340		
	representatives, and designated representatives.		•		
	by: Based on interview facility failed to read	ent is not met as evidenced and document review, the amit residents after a of 1 resident (R147) reviewe	ed	Corrected	
	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.		d		
	the emergency dependent of the emergency depende	on contacted the facility be ready for discharge and return to the facility that sam is told by facility staff they readmit the resident after	S		

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	PROVIDER OR SUPPLIER	AB CENTER 416 SEV	, ,	TATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COMMERCE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 340	 - 2/20/23, R147's envisit notes identified 5:12 a.m. and was further care. - 2/25/23 at 10:00 progress notes identified place R147 comfort 	ige 8 s identified the following: mergency department (ED) d R147 arrived at the ED at admitted to the hospital for p.m., the medical center daily ntified R147's family decided to t cares and planned to ck to the nursing home for	2 340			
	- 2/27/23 at 10:08 at Ombudsman left at on 2/25/23, and the call and left a voice transfer R147 back the facility had been resident. The programmy R147 was not a - 2/27/23 at 11:03, Fundate to the facility	tes identified the following: a.m., the Long-Term Care voicemail for the administrator administrator returned the mail. The hospital wanted to to the facility on 2/25/23, but a unable to accept the ress notes failed to identify accepted for transfer. R147's son provided an y regarding the residents tus. R147's family had wanted the facility.				
	attempted to reach	p.m., a phone call was the facility ombudsman's and budsman was out of the office				
	social worker (SW) transferred out of the responsible for obtained accept the resident medically stable. Start a resident is readmi	9/19/23 at 3:12 p.m., the stated when a resident was ne facility, the nurses were aining a written or verbal hold indicating the facility would back when they were taffing should not affect when itted to the facility. According notes, the hospital case				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED		
		00974		B. WING			C 20/2023
	PROVIDER OR SUPPLIER	AB CENTER	416 SEVE		STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENT MUST BE PRECEDED SCIDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 340	manager called inquesident back to the unable to readmit during interview on hospital case mana R147 was admitted On 2/22/253, R147 due to R147's declihospital talked with coordinate a care of update on residents the hospital case managed to a bed hold facility agreed to an the resident when the would expect the facility agreed to a bed hold expect the facility agreed to an the resident when the would expect the facility agreed to a bed hold expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the resident when the would expect the facility agreed to an the wou	uiring about reading facility but the set of re-admit the set of the hospital facility elected on the hospital facility elected on the facility elected with the set of health status. On an ager talked with the facility would be set of R147 but the resident over the resident over the facility of the facility which is a could not refusively were medical hey were medical	a registered R147. a.m., the On 2/20/22, or acute care. comfort care 2/23/23, the was trying to be facility to On 2/24/23, the he weekend by were he weekend by verbally a meant the e to readmit lly stable. CM				
	During interview on director of nursing of was transferred to the work with the hospit accommodate the readmission, included weekends. The factoreadmissions during is when the admitting should have been received comfort careadmitting over the allowed to die at R1 comfortable with he progress noted lack discharge and read	(DON) stated when the hospital, the fatal case manager residents needs a ing readmissions ility was currently go the work week lares in R147's home where the family nearby. Faced evidence of the fatal case of the fatal cases in R147's home where the family nearby. Fatal cases in R147's home where the family nearby. Fatal cases in R147's home where the family nearby. Fatal cases in R147's home where the family nearby. Fatal cases in R147's home where the family nearby. Fatal cases in R147's home where the fatal cases in R147	en a resident acility would to and plans for only taking because that R147 facility and ome. By not was not each was acident R147's acrough				

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		` ′	ATE SURVEY OMPLETED	
		00974	B. WING		09/2) 20/2023	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
CORNER	RSTONE NSG & REHA	AB CENTER	, MN 56621	T NORTHEAST			
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2 340	Continued From page 10		2 340				
	DON was unable to	R147's progress notes the determine if the facility the effort to readmit R147.					
	reviewed 10/24/22,	of Bed Hold Policy and Return identified a resident would be cility to the first available bed neet their needs.					
	A readmission polic received.	y was requested but not					
	The DON/ Administ and revise readmiss	HOD OF CORRECTION: fror or designee could review sion to the facility procedures; aff regarding the expectations; asure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21530	A. The drug regim reviewed at least modurrently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lotthe Department of Health Care Finance This standard is incavailable through the system. It is not surveyor B. The pharma irregularities to the and the attending process.	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next				10/20/23	

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00974	B. WING		09/2	20/2023
	PROVIDER OR SUPPLIER	AB CENTER 416 SEVE		STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	pharmacist. For purpon" means the acreport and the signification for the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to the medical direct physician does not must be referred for assessment and as by part 4658.0070.	ooner, if indicated by the irposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concurt's recommendation, or does te justification, and the sthe resident's quality of life is ected, the pharmacist must the medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter is review to the quality surance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.				
	by: Based on interview facility failed to ensire recommendations v	ent is not met as evidenced and document review the ure pharmacy consultants were followed up on in a timely esidents (R29, R32) reviewed agement.		Corrected		
	8/4/23, identified R2 impairment with dia dementia, and Huninherited disease the	imum Data Set (MDS) dated 29 had moderate cognitive ignoses of non-Alzheimer's tington's disease (a rare, nat causes the progressive eration) of nerve cells in the				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00974	B. WING		09/2	20/2023
	PROVIDER OR SUPPLIER	B CENTER 416 SEVE		STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Review Physician R 3/23/23, identified R antidepressant and tablets. The Centers Services (CMS) red psychotropic (medication psychotropic psychotropic (medication psychotropic psychotropic psychotropic psychotropic (medication psychotropic psych	antianxiety and lications. harmacist's Medication Recommendation dated R29 received trazodone (an sedative) 50 milligram (mg) is for Medicare and Medicaid quired evaluation of cations which affect a person's rations. This was to be as possible but no later than dical provider reviewed and consulting Pharmacist on 9/20/23. It was over 180 rendation was given and was rethe surveyor requested the rovider noted "drug d/c ady" and was rejected but did it happened. on 9/20/23 at 1:27 p.m., the DON) stated there as a period acility did not received any cist's Medication Reviews roortal and some may have acility did not call the set the medication reviews. Hew would be expected to be set stated time periods to be reen treceiving unnecessary redication review from dressed until 9/20/23, after dated 7/24/23, identified R32 included dementia, ar disorder and anxiety. R32 included dementia, ar disorder and anxiety. R32 included ressent and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED		
		00974		B. WING			C 20/2023
	PROVIDER OR SUPPLIER	AB CENTER	416 SEVE	,	STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENT MUST BE PRECEDENTED INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT (CROSS-REFERENCE)	OULD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 13		21530			
	R32's Consulting P Review Recomment identified R32 receips secretion reducer) a suggested to either (only if appropriate) rationale) why the consulting Pharma 1/18/23, and noted R32's Consulting Pharma 1/18/23, and noted R32's Consulting Pharmacist suggested antidepressant) 20 evaluation of psychopharmacist suggested reduction (only if appropriate) (with clinical rational outweighed the risk R32's medical provon the Consulting Pon 9/20/23. It was a recommendation was after the State Agent information. The propriate processed, continuation and the consulting Pon 9/20/23 and the commendation was after the State Agent information. The processed, continuation continuation and the consulting Pon 9/20/23 and the commendation was after the State Agent information. The processed, continuation continuation continuation continuation continuation.	red famotidine (a 20 mg tablets. The consider a dose or to document surrent benefits of current dose. R3 and signed off on cist Mediation Red (a mg capsules. Charmacist's Mediation dated 2/2 ved fluoxetine (a mg capsules. Charmacist medication development of the constant of the constan	a gastric acid he pharmacist reduction (with clinical utweighed the 2's medical the eview dated in cons." Ication 1/23, n //S required on. The sider a dose document ent benefits current dose. It is a signed off cation review er the y addressed ed the				
	R32's Consulting P Review Recomment identified R32 received secretion reducer) and a gastric acid secretion pump inhibitor (PPI capsules . The phase continued to take be secretion should be the PPI alone. The	dation dated 3/2 ved famotidine (a 20 mg tablets and etion reducer and macist identified oth mediation and adequately supposed the supposed and equately s	8/23, a gastric acid d omeprazole d proton l release (DR) l R32 d acid oressed with				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED	
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21530	acid reducers and of the medications, if provider reviewed a Consulting Pharma on 9/20/23. It was of recommendation wafter the State Ager information. The prefamotidine, continued During a interview of DON stated the form "doing" the pharma the role in January was emailing the photon but there was a DO role. During that time a "portal" system an access. There was pharmacists during unsure of the timelitime when the facility medication reviews get access for a "country that the Consultant Pharma Recommendations important because use of unnecessary error. During a telephone	ing the ongoing need for both consider discontinuing one of possible. R32's medical and signed off on the cist Medication review dated over 180 days after the as given and only addressed acy (SA) requested the ovider noted "discontinue e omeprazole." on 9/20/23 at 1:23 p.m., the mer DON was receiving and cy reviews prior to her leaving 2023. After that, the pharmacy narmacy reviews "for a while" on that temporarilly filled the ne, the pharmacy began using and the facility did not have a change in consultant this time. The DON was ne but was aware there was a ty had not received pharmacy because the facility did not ouple" of months. Review of rmacist's Medication Review in a timely manner was it could potentially lead to the medication or a medication interview on 9/20/23 at 2:50	21530				
	were reviewed mongenerated for the factor the role in May 202 all recommendation the same pharmacy were sent to the factor.	stated all active residents Ithly and reports were Icility. Pharmacist-B took over It is, however, was able to review It is prior to that because it was It is system. Once the reports It is if there was a It is ing might take care of it or					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	If there were no recomould list the review pharmacist-B would report to determine responded to. If not the recommendation within 60 days. The was to help the nurs recommendations of the provide assistance requirements. Pharmacisted the factor reported to him inal had assisted the factor recommendations within 60 days. The facility policy P dated 11/14/22, idea review periodically were still necessary example, whether a risk factors were surenduring that they recontinue the currenconditions and risks well managed or commedications, or with policy failed to identify pharmacist's role not consulting Pharmacist's role not	arded to the medical provider. ommendations, the report of as such. Typically, I review the prior month's if all recommendations were, pharmacist-B would resend in so it would be addressed consultant pharmacist role sees to ensure all overe responded to and to to staff to meet regulation macist-B stated the facility polity to access the portal and cility to gain access. Yes, the should have been addressed the physician would whether current medications or in their current doses; for an individual's conditions or equire medication therapy to the dose, or whether those is could potentially be equally introlled without certain in a lower dose. However, the cify the consultant for the timeframe when a cist's Medication Review hould be addressed. HOD OF CORRECTION: the could review and revise the pharmacist and the lities regarding the medication cursing staff; then audit to	21530			

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NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	RSTONE NSG & REHA	B CENTER		NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 16		21530			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		y-one				
21535	21535 MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General			21535			10/20/23
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the present which indicate the discontinued. In addition to the discontinued.	quate indications for its unce of adverse consequences should be reduced fug regimen review requesting home must consequence interpretive Guidelines and Fill Guidance to Surveyors cilities, published by the thand Human Services ing Administration, April orporated by reference e Minitex interlibrary loaded Law Library. It is not	ise; or ences or in mply s for on 1992. It is in				
	by: Based on interview facility failed to ensure was evaluated for notes of 5 residents (R32)	and document review, the and document review, the cessity by the physicial is for 1 of 5 residents (Ressary medication.	he on n for 2 ation		Corrected		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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21535	Continued From pa	ge 17	21535			
	Findings include: R32's annual MDS had diagnoses that failed to identify if R reflux disease (GEF disease where the I refluxes into the eso the mouth and store R32's Physician Ore 8/28/23, identified the mouth and store R32's Physician Ore 8/28/23, identified the R32's Consulting Place and proton milligrams (mg) caponce a day. R32's Consulting Place and ome prazole 20 capsules. The pharmal continued to take be secretion should be the PPI alone. The consider re-assessing acid reducers and of the medications, if provider reviewed a Consulting Pharmal 9/20/23. It was over recommendation was after the State Ager	dated 7/24/23, identified R32 included dementia. The MDS (32 had gastroesophageal RD) (A chronic digestive iquid content of the stomach ophagus, the tube connecting nach) or ulcer. der Report dated 7/28/23 - ne following: ole (a gastric acid secretion pump inhibitor (PPI)) 20 osules. One capsule by mouth e (a gastric acid secretion lets. One tablet by mouth once tharmacist's Medication dation dated 3/28/23, wed famotidine 20 mg tablets of mg delayed release (DR) remacist identified R32 oth mediation and acid adequately suppressed with pharmacist suggested to ng the ongoing need for both consider discontinuing one of cossible. R32's medical and signed off on the cist Medication review on				
	recommendation was	as given and only addressed ncy (SA) requested the ovider noted "discontinue				

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		00974	B. WING			C 20/2023	
	PROVIDER OR SUPPLIER	AB CENTER 416 SE	ADDRESS, CITY, S VENTH STREE EY, MN 56621	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21535	director of nursing (unaware of R32's d morning when the C Medication Review requested. Reviewi Pharmacist's Medications important because use of unnecessary error. Nursing shou medications during R32's provider for g R2's quarterly Mining 9/5/23, identified R2 had a suprapubic caincluded multiple so bladder. R2 had ta during the assessmant R2's urinary Care A 4/5/23, identified R2 UTI and took a sing antibiotic for prophy (UTI). R2's care plan revising antibiotic for prophy (UTI). R2's care plan revising antibiotic for prophy (UTI).	on 9/20/23 at 1:23 p.m., the (DON) stated she was duplicate medication until that Consulting Pharmacist's Recommendation forms weright a timely manner was it could potentially lead to the medication or a medication and have reviewed R32's assessments and contacted guidance. The manner was it could potentially lead to the medication or a medication and have reviewed R32's assessments and contacted guidance. The manner was it could potentially lead to the medication or a medication and contacted guidance. The manner was it could potentially lead to the medication of the medication of the medication of the medication was cognitively intact and atheter. R2's diagnoses believes and neurogenic ken an antibiotic one time ment period. The assessment (CAA) dated the period was a week, rotating year and a week, rotating year and a week, rotating year and status and directed staff to signs and symptoms of UTI ls, bladder spasms, and ers report dated 7/6/23, rescribed the following	re e d of d				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		`	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED		
		00974	B. WING			C 20/2023	
	PROVIDER OR SUPPLIER	AB CENTER 416 SEVE	, ,	TATE, ZIP CODE T NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21535	of the month amoxicillin-pot clarablet once a day of month cephalexin 500 m mouth once a day of month. R2's pharmacy med (MMR) dated 9/18/2 suggested R2's dod of the antibiotic's (a effectiveness would for resistance to all increased) for chromogramacist request current benefits out medical doctor (MD stated R2's urologist needed to continue failed to identify where-assessed by the R2's progress notes - On 9/15/23, 7/6/23 and 9/15/22, R2 was (MD) on rounds. The antibiotics R2 was the Con 6/28/23, 4/17/2 MDS assessment resingle day a week, prophylactic UTI. During interview on licensed practical in different antibiotics of Monday's of each in urologist prescribed.	vulanate 875-125 mg take one in the 3rd Monday of the grapsule take one capsule by on the 4th Monday of the dication monitoring review 22, identified the pharmacist ctor re-assess the ongoing use it the current dose be questionable and the risk four antibiotics maybe nic UTI prophylaxis. The red a clinical rationale if the tweighed the risks. The one of the suggestion and it recommended the resident the antibiotics. The MMR en the antibiotics had been	21535				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		00974	B. WING	_		C 20/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNE	RSTONE NSG & REHA	AB CENTER	NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH) CROSS-REFERENCED TO THE APPROPRIES (PROVIDENCY)	OULD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 20	21535			
	a long time.					
	medical doctor state past and the urolog	9/20/23 at 2:19 p.m., R2's ed R2 had multiple UTI's in the ist wanted R2 to continue on en. R2 was the urologist in the				
	requested and not reprovide documentations were being reviewe	tes for the last year were received. The facility failed to tion that R2's medications d by a urologist and there was ohylactic antibiotic use.				
	DON stated R2 was was taking the antikadmission. The DO were reviewed upon if they had been revantibiotic regimen standadmission. Inapproto organisms being could limit the type by R2, could potent	9/20/23 at 1:01 p.m., the sadmitted on 7/15/22, and piotic regimen prior to ON thought the medications in admission but was uncertain viewed since that time. R2's should have been reviewed by the doctor since R2's priate antibiotic use could lead resistant the antibiotics used, of antibiotics available for use ially be harmful to R2 and discould cause R2 to receive otics.				
	dated 11/14/22, idea review periodically were still necessary example, whether a risk factors were su enduring that they recontinue the current conditions and risks	harmacy Services Overview ntified the physician would whether current medications in their current doses; for an individual's conditions or equire medication therapy to t dose, or whether those sould potentially be equally entrolled without certain a lower dose.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
		00974	B. WING		09/2) 0/2023
	PROVIDER OR SUPPLIER	AB CENTER 416 SEV	,	STATE, ZIP CODE T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 21	21535			
	facility failed to ensumedication had a dephysician for continued residents reviewed medications. Findings include: R32's annual MDS had diagnoses that disorder and anxiet antidepressant medications. R32's psychotropic Assessment (CAA) continued to take an adverse effects. R3 current. R32's Consulting Place R32's Consulting R32's Consulting Place R32's Consulting R32's Consulting R32's Consulting R32's Consulting R32's Consulting R32's Consulting R32'	drug use Care Area) dated 7/24/23, identified R32 ntidepressant without any 2's care plan remained harmacist's Medication dation dated 2/21/23,				
	CMS required evaluation. The photostider a dose reconsider a dose. Reconsider and signed the current dose. Reconsider and signed Pharmacist Medicar	milligrams (mg) capsules. Lation of psychotropic armacist suggested to either duction (only if appropriate) or clinical rationale) why the eweighed the risks to stay on 32's medical provider ed off on the Consulting tion review on 9/20/23. It was				
	given and only addr (SA) requested the noted the recomme	the recommendation was ressed after the State Agency information. The provider endation for gradual dose cted" and "patient still e."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00974	B. WING		C 09/20/2023
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE	
CORNER	RSTONE NSG & REHA	AB CENTER	ENTH STREE , MN 56621	T NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21535	Continued From pa	ge 22	21535		
	through 8/29/23, fair fluoxetine use. During a interview of director or nursing unaware of the Cor	ogress notes dated 9/20/23 filed to identify the rationale for on 9/20/23 at 1:23 p.m., the (DON) stated she was isulting 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.				
	dated 11/14/22, ide review periodically were still necessary example, whether a risk factors were su enduring that they recontinue the current conditions and risks	harmacy Services Overview ntified the physician would whether current medications in their current doses; for an individual's conditions or afficiently prominent or equire medication therapy to t dose, or whether those is could potentially be equally entrolled without certain in a lower dose.			
	The DON or design policies regarding of justification for cont	HOD OF CORRECTION: nee could review and revise luplicate medication therapy. inued use and gradual dose nursing staff; then audit to			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			

6899

Minnesota Department of Health STATE FORM

F5307033

PRINTED: 10/16/2023 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION TO IDENTIFICATION NITIMBED:		` ′	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED		
		245307	B. WING		09/2	22/2023
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-S	K 0	00		
	conducted by the M Public Safety, State 09/22/2023. At the Cornerstone Nursin not in compliance w participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S PO ALLEGATION OF CO DEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CMS USED AS VERIFICA	ety recertification survey was innesota Department of Fire Marshal Division on time of this survey, g & Rehab Center was found with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection 101, Life Safety Code (LSC), Health Care and the 2012 Health Care Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	CONDUCTED TO N SUBSTANTIAL COI REGULATIONS HA ACCORDANCE WI	MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.				
	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY				
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).				
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

Electronically Signed

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	l `´´	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING	` '	(X3) DATE SURVEY COMPLETED	
		245307	B. WING _		09/	22/2023	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	DEFICIENCY MUS FOLLOWING INFO. 1. A detailed described taken or planned to a sure the place to ensure the sustained. 3. Indicate how the future performance sustained. 4. Identify who is actions and monito.	pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION: cription of the corrective action of correct the deficiency. easures that will be put in deficiency does not reoccur. the facility plans to monitor to ensure solutions are responsible for the corrective	KO				
	built in 1968, is a 1-basement and was (222) construction. basement addition determined to be of In 2016 an addition west wing and was (111) construction. completely remode	ursing and Rehab Center was story building, with a partial determined to be of a Type II A 1 story building without was added in 2015 and was f Type V(111) construction. was added to the end of the determined to be of a Type V The 1968 building was led at that time. The two types not separated by a 2 hour fire					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					` '	E SURVEY IPLETED	
		245307	B. WING			09/	22/2023
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP C 416 SEVENTH STREET NORTHEAS BAGLEY, MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
K 353	The facility is complan automatic sprink accordance with NF Installation of Sprink a fire alarm system with additional autocommon use space NFPA 72 "The National The facility has a cacensus of 45 at the The requirements a are NOT MET as exprinkler System - I CFR(s): NFPA 101 Sprinkler System - I Automatic sprinkler inspected, tested, a with NFPA 25, Stantesting, and Mainta Protection Systems maintenance, inspermaintained in a section and the section of the section o	I the requirements to be pe V (111) building. I tetely sprinkler protected with the system installed in FA 13 Standard for the kler Systems. The facility has with corridor smoke detection matic smoke detection in all is installed in accordance with onal Fire Alarm Code". I the pacity of 47 beds and had a stime of the survey. Ith 42 CFR, Subpart 483.70(a), widenced by: I waintenance and Testing and standpipe systems are not maintained in accordance dard for the Inspection, ining of Water-based Fire. I Records of system design, ction and testing are ure location and readily system last checked system test	K 0				10/20/23
		12					

AND DIANIOE CODDECTION I DENTIFICATION NI IMBED:					E SURVEY IPLETED	
	245307	B. WING		09/:	22/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CORNERSTONE NSG & REHA	AB CENTER		416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
by: Based on observat facility failed to mai and the sprinkler sy edition), Life Safety (2011 edition), Stan Testing, and Mainte Protection Systems 13 (2010 edition), S Sprinkler Systems, These deficient find on the residents wit Findings include: On 09/22/2023, bet was revealed by ob materials had been bringing the storage 18 inch clearance a These obstructions 1) Clerical Office 2) End of 400 Wing 3) Lower Level Storage An interview with the	and NFPA 25 NT is not met as evidenced tion and staff interview, the ntain spacing between storage ystem per NFPA 101 (2012 y Code, Section 9.7.5, NFPA 25 ndard for the Inspection, enance of Water-Based Fire s, Section 5.2.1.2, and NFPA Standard for the Installation of Sections 8.6.5.3.2 and 8.15.9. dings could a patterned impact thin the facility. tween 9:30am and 1:30pm, it part is provided a patterned impact the placed on a storage a placed on a storage rack, e materials within the required area under the sprinkler heads. Exercise were found in:	K 3	All items have been removed from of the storage racks to ensure the least an 18-inch clearance area us sprinkler heads in the clerical officend of the 400 wing and in the low storage room. All other potential a throughout the facility have been inspected for compliance. Audits areas as well as all other areas throughout the facility will be compweekly for 4 weeks, monthly for 2 and quarterly thereafter. These a have been added to the facility preventative maintenance prograr ensure compliance. The Environr Services Supervisor shall be respifor ensuring audits are completed compliance is maintained. Result be reviewed at QAPI to ensure compliance and determine if addit monitoring is necessary.	re is at nder the e, the e, the er-level areas of these ndertal ensible and s shall		