Electronically Delivered

February 18, 2026

Licensee
Cornerstone Residence Fosston
115 1st Street East
Fosston, MN 56542

RE: Project Number(s) SL30360015

Dear Licensee:

On May 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 21, 2023. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Electronically Delivered

March 31, 2023

Licensee
Cornerstone Residence Fosston
115 1st Street East
Fosston, MN 56542

RE: Project Number(s) SL30360015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 21, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30360015-0 On March 20, 2023, thru March 21, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 26 active residents; 24 whom were receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure infection control standards were followed for two of two of residents (R7, R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally or in a limited number of locations). The findings include: On March 21, 2023, at 7:19 a.m., evaluator observed unlicensed professional (ULP-G) perform a blood pressure (BP) on R7, and R12 using the same automatic upper arm BP cuff. ULP-G failed to disinfect the reusable BP cuff in between residents. On March 21, 2023, at 1:03 p.m., evaluator interviewed registered nurse (RN-E) and asked	0 510		

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0 510	Continued From page 2 what the expectations were after the use of the automatic BP cuff. She stated the ULPs are to disinfect it by spraying and wiping it down after each use. The licensee's Cleaning of Share Medical Equipment policy and procedures dated August 1, 2021, noted to clean non-critical medical equipment surfaces with a mild detergent followed by cleaning with a disinfectant. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have locks, on two of the emergency exit doors in the memory care unit, that release upon	0 820		

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0 820	Continued From page 3 a power outage and when fire alarms are activated. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On March 21, 2023, from approximately 10:10 a.m. to 11:45 a.m., survey staff toured the facility with Administrator (A)-B and Maintenance (M)-F. During the facility tour, survey staff observed and verified the facility Emergency exit doors in the memory care unit have doors that do not trigger a release of the locks when the fire alarm system goes off. These locks are however, released when there is a power outage but only by a battery backup system. A-B and M-F verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 4 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on March 20, 2023, at 10:20 a.m., the evaluator asked for a copy of the licensee's assisted living contract. The assisted living contract was provided to and later reviewed by the evaluator. The assisted living contract provided included a clause that indicated the resident would waive the facility's liability health, safety, or personal property of the resident. Pages nine (9) and 10, section 17. Personal Property, indicated the resident agrees the provider is not responsible for any loss or damage to resident's personal	0 970		

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0 970	Continued From page 5 property due to any reason or cause, including theft, other than provider's own negligence. Resident further agrees that provider is not responsible for damage to resident's personal property due to fire, water, tornado or other acts of nature and events beyond provider's control. On March 20, 2023, at 1:53 p.m., administrator (A)-B stated he was aware this section of the contract needed to be updated. A-B confirmed the assisted living contract provided was the same contract used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the licensed assisted living director/clinical nurse supervisor (LALD/CNS-A) conducted a medication management reassessment with a change in condition for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01710		

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01710	Continued From page 6 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation occurred only occasionally). The findings include: During the entrance conference on March 20, 2023, at 9:58 a.m., LALD/CNS-A stated the licensee provided medication management to residents. R3's diagnoses included dementia with behavior disturbance, depression with anxiety and paranoid schizophrenia (debilitating symptoms that blurs the line between what is real and what isn't, making it difficult for the person to lead a typical life). R3's prescriber orders dated July 5, 2022, included a standing order that noted Cornerstone nurses or personal assistants may crush or dissolve (in a medications liquid) medications as appropriate and per policy. On March 21, 2023, at 8:38 a.m., evaluator observed unlicensed personnel (ULP-C) administer crushed medications in pudding to R3. R3's Service Plan dated July 30, 2022, indicated the resident was receiving medication management, including set-up and medication administration. R3's Medication Assessment and Management Plan dated April 22, 2023, indicated resident to take medications whole.	01710		

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01710	Continued From page 7 On March 21, 2023, at 3:15 p.m., LALD/CNS-A stated the medication management plan must not have been updated. The licensee's Medication Management-Assessment, Monitoring and Reassessment dated August 1, 2021, indicated [licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01760		

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01760	Continued From page 8 review, the licensee failed to ensure the pill count could be verified by the unlicensed personnel (ULP) with medication administration of one of three residents (R3); failed to ensure medications were setup per manufacturer's instructions for one of two resident (R4); and failed to ensure the pill count was transcribed accurately on the electronic medication administration record (EMAR) for one of three residents (R9) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CRUSHED MEDICATIONS R3's diagnoses included dementia with behavior disturbance, depression with anxiety and paranoid schizophrenia (debilitating symptoms that blurs the line between what is real and what isn't, making it difficult for the person to lead a typical life). R3's Medication Assessment and Management Plan dated April 22, 2023, indicated resident received medication management services which included medication administration and set-up. R3's prescriber orders dated July 5, 2022, included the following oral Monday afternoon medications to be administered: -acetaminophen 325 milligram (mg), 2 tabs (pain reliever)	01760		

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01760	Continued From page 9 -calcium/vitamin d 600-400 mg unit (vitamin) -vit d-3 1000 unit (vitamin) -potassium chloride extended release (ER) 20 milliequivalent (MEQ) tab extended release (TBCR) (low potassium) On March 20, 2023, at 1:39 p.m., evaluator observed ULP-C prepare R3's afternoon medications for administration. ULP-C obtained a plastic box containing white envelopes with a clear sleeve of pre-crushed medications inside. Designated on the white envelopes was R3's name, date of birth, medical record number, day of the week and time. ULP-C placed R3's crushed medications out of the Monday, 2:00 p.m. medication envelope into a medication cup. ULP-C checked R3's electronic medication administration record (EMAR) which under the 2:00 p.m., "Medication Administration" section it indicated the pill count to be delivered was "5 pills". ULP-C stated she could not verify the number of pills with the EMAR due to the medication already being crushed. Evaluator observed ULP-C administer crushed medications in pudding to R3. Manufacturer instructions for the use of potassium chloride ER, dated August 2022, included to take each dose without crushing, chewing, or sucking the tablets. If those patients are having difficulty swallowing whole tablets, they may try one of the following alternate methods of administration: - Break the tablet in half and take each half separately with a glass of water. - Prepare an aqueous (water) suspension as follows: - place the whole tablet(s) in approximately 1/2 glass of water (4 fluid ounces), - allow approximately 2 minutes for the tablet(s)	01760		

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01760	Continued From page 10 to disintegrate, - stir for about half a minute after the tablet(s) has disintegrated, - swirl the suspension and consume the entire contents of the glass immediately by drinking or by the use of a straw, - add another 1 fluid ounce of water, swirl, and consume immediately and - and an additional 1 fluid ounce of water, swirl, and consume immediately. On March 21, 2023, at 2:54 p.m., licensed assisted living director/clinical register nurse (LALD/CNS-A) stated the process for medication administration is the ULP verifies the number of pills in the set up to the number of "pill count" in the EMAR. Evaluator inquired if the medications are crushed how do the ULPs verify the "pill count". She stated they cannot verify the count if medications are crushed. INSULIN PEN SETUP R4's diagnoses included dementia with behavior disturbance, Pick's disease (a less common type of dementia that affects the frontal lobe and exhibits symptoms such as changes in personality and behavior, and/or difficulties with language), diabetes, and obesity. R4's prescriber orders dated April 22, 2022, included an insulin order for Basaglar100 units/milliliter, 62 units to be administered every morning. R4's Medication Assessment and Management Plan and service plan dated April 7, 2022, and December 19, 2022, respectively indicated R4 received medication management services which included medication administration and setup.	01760		

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01760	Continued From page 11 On March 20, 2023, at 11:14 a.m., the evaluator toured the facility with LALD/CNS-A. The evaluator observed in the medication cupboard of the memory care unit three (3) pre-drawn insulin syringes in a clear plastic glass in R4's medication bin. Each pre-drawn insulin syringe was labeled with R4's name, Basaglar 62 units and initials of who had setup the insulin [registered nurse (RN)-E]. LALD/CNS-A stated it was the facility's practice since Basaglar insulin was only distributed in an insulin pen and was not available in a vial; the nurses setup the weekly insulin syringes by withdrawing Basaglar insulin directly from the insulin pen into an insulin syringe. LALD/CNS-A stated a pharmacist told them this was "okay to do". On March 20, 2023, at 3:28 p.m., RN-E stated she sets up the insulin syringes for all the residents every Thursday. RN-E stated all insulin was either drawn up from an insulin pen or an insulin vial (if available). RN-E articulated the procedure she used when withdrawing insulin from an insulin pen was as follows: she removes the cover from the insulin pen; swabs the top of the pen with an alcohol wipe; takes the insulin syringe which she has already pulled back the plunger to the ordered amount of insulin that needs to be drawn up and punctures the rubber seal on the tip of the insulin pen with the insulin syringe; expels the amount of air that was preset on the insulin syringe into the insulin pen; withdraws that same amount of insulin from the insulin pen into the insulin syringe [which is the amount of insulin units ordered]; removes the insulin syringe from the insulin pen and places the label on the preset insulin syringe. RN-E stated this was the same practice the facility used for anyone that had an insulin pen ordered as their unlicensed personnel/ULP have not been	01760		

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01760	Continued From page 12 trained on how to administer insulin via an insulin pen. RN-E stated she was told the ULP have not been trained due to the amount of training the ULP would have to have to be able to administer insulin via an insulin pen. RN-E was unsure if drawing up insulin from an insulin pen was an acceptable practice. On March 21, 2023, at 2:59 p.m., RN-E stated the facility had been drawing up insulin from an insulin pen "forever". LALD/CNS-A stated the facility had received a verbal confirmation from the pharmacist [unsure of when] that this was okay to do. LALD/CNS-A confirmed she was unsure if this was a current acceptable practice. The manufacturer's instructions for the use of Basaglar insulin pens, dated November 2022, included the following instructions for preparing the insulin pen for administration: - pull the pen cap straight off the pen - check the liquid in the pen - select a new needle and push the capped needle straight onto the pen - prime the pen - dial up the selected dosage of insulin; and - administer the correct dose of insulin The Primary Care Diabetes Society Improving Insulin Safety: An Ongoing Campaign dated November 3, 2016, noted prefilled pens and cartridges are not designed to have the insulin extracted and the practice is not endorsed by any of the manufacturers. This practice can damage the device, lead to dosing errors, and potentially result in patient harm. The NHS (National Health Service) Patient Safety Alert - Risk of severe harm and death due to withdrawing insulin from pen devices dated	01760		

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01760	Continued From page 13 November 16, 2016, noted if insulin extracted from a pen or cartridge is of a higher strength, and that is not considered in determining the volume required, it can lead to a significant and potentially fatal overdose. Extracting insulin from pen devices also risks damaging the device's mechanism. TRANSCRIPTION ERROR R9's diagnoses included atrial fibrillation (irregular often fast heartrate), hypertension (high blood pressure), congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), dementia, and chronic kidney disease. R9's Medication Assessment and Management Plan and service plan dated February 7, 2023, and February 14, 2023, respectively, indicated R9 received medication management services to include medication administration and setup. R9's prescriber orders dated January 5, 2023, included the following oral Tuesday morning medications to be administered: - alfuzosin HCL ER 10 mg (medication to treat urinary retention) - ascorbic acid 1000 mg (vitamin) - cetirizine HCL 10 mg (antihistamine) - finasteride 5 mg (medication to treat urinary retention) - Lasix 20 mg (take ½ of a Lasix 40 mg tablet) (diuretic) - metoprolol succinate ER 50 mg (antihypertensive) - vitamin B complex 1 tablet On March 21, 2023, at 8:12 a.m., [Tuesday] evaluator observed ULP-C prepare R9's morning medications for administration. ULP-C obtained	01760		

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01760	Continued From page 14 from a preset pill planner (a plastic medication box with designated compartments for days and times) R9's medication out of the Tuesday morning compartment. ULP-C placed six whole tablets and one ½ tablet into a medication cup. ULP-C checked R9's medication administration record (MAR) which under the 8:00 a.m., "Medication Administration" section indicated the pill count to be delivered was "Wed & Sat = 6 whole 2 half (+ 1 from 8/2-9/9) - all other days 5 whole 2 half". ULP-C recounted the medications in the medication cup and stated the count was not accurate as there were six whole tablets and one ½ tablet. ULP-C stated she will need to call LALD/CNS-A. On March 21, 2023, at 8:17 a.m., LALD/CNS-A reviewed R9's MAR and verified the pill count transcribed on R9's MAR for his 8:00 a.m. medication pass did not coincide with the number of pills that had been setup in R9's planner. LALD/CNS-A reconciled R9's morning medications by reviewing the MAR and reconciling them with the prescription bottles. On March 21, 2023, at 8:26 a.m., LALD/CNS-A stated the correct number of pills had been setup in R9's pill planner for his Tuesday morning medication pass (six whole tablets and one ½ tablet). LALD/CNS-A stated it was a transcription error on R9s MAR and at 8:31 a.m., proceeded to change the 8:00 a.m., pill count directions on R9s MAR to "Pill Count - Wed & Sat = 7 whole 1 half - all other days 6 whole 1 half". LALD/CNS-A stated she was unsure how long this transcription error had gone on. The licensee's Medication Management - Administration and Setup policy dated August 1, 2021, noted the ULP will verify medications are	01760		

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01760	Continued From page 15 set up correctly in the dosage box before administration to the resident by use of the medication profile and verifying the correct number of pills are set up. Also, the licensed nurse who sets up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance, and will initial that this has been done and medication regimen will be updated and reviewed at the same time of medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's recommended temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01880		

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01880	Continued From page 16 The findings include: On March 20, 2023, at 11:28 a.m., the evaluator toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, including a review of the medication refrigerator in the locked nurses station. LALD/CNS-A stated the current temperature of the medication refrigerator was 40 degrees Fahrenheit (F). The refrigerator contained the following medications: - one in use Basaglar 100 units/milliliter (ml) insulin pen with a date when opened of "3/14" for R4 - one in use Basaglar 100 units/ml insulin pen with a date when opened of "2/23" for R6 - one in use Lantus 100 units/ml insulin pen with a date when opened of "3/14" for R7 On March 20, 2023, at 11:33 a.m., the evaluator reviewed the storage instructions on the packaging boxes of the Basaglar and Lantus insulin pens with LALD/CNS-A. The instructions for both insulin pens indicated in use (opened) insulin pens should be stored at room temperature. LALD/CNS-A stated she was unaware of this, and the open insulin pens should not be stored in the refrigerator. The manufacturer's instructions for Basaglar insulin pens dated November 2022, indicated in use (opened) insulin pens should be stored at room temperature (up to 86 degrees F) for 28 days. Do not refrigerate. The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated in use (opened) insulin pens should be stored at room temperature only. Do not refrigerate.	01880		

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01880	Continued From page 17 The licensee's Medication Storage policy dated August 1, 2021, noted medications managed and stored by the facility should be kept securely locked and stored per manufacturer's directions. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of five residents (R3, R6) and failed to monitor for expired medications for one of five residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	01890		

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01890	Continued From page 18 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 20, 2023, at 10:48 a.m., the evaluator toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, including a review of the locked medication cart and medication rooms. LALD/CNS-A observed and confirmed the following: DATING TIME SENSATIVE MEDICATIONS R3 R3's open bottle of latanoprost 0.005% ophthalmic solution (glaucoma medication) did not have a label which indicated the date the bottle of latanoprost had been opened and when the bottle of solution would expire. R6 R6's open bottle of Ciprofloxacin 0.3% ophthalmic solution (antibiotic) did not have a label which indicated the date the bottle of Ciprofloxacin had been opened and when the bottle of solution would expire. EXPIRED MEDICATION The following medication was found to be expired: - R8's opened tube of fluocinonide 0.05% cream (used to treat dry skin) expired August 2022 On March 20, 2023, at 10:56 a.m., LALD/CNS-A stated the medications in the medication cart and medication bins were supposed to be checked every Tuesday by the nurse for expired medications and to make sure medications were	01890		

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01890	Continued From page 19 dated appropriately. LALD/CNS-A stated the above noted medications must have just been missed. The manufacturer's instructions for the use of latanoprost eye drop solution dated September 2020, directed for the eye drop solution to be discarded six weeks after it had been opened. The manufacturer's instructions for the use of Ciprofloxacin eye drop solution dated March 15, 2018, directed to write the date on the bottle when you open the eye drops and throw out any remaining solution after four weeks. The licensee's Medications - Prescription Drugs and Prohibition policy dated August 1, 2021, noted when the facility receives a prescription drug, the drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940		

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01940	Continued From page 20 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R3, R4) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has	01940		

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01940	Continued From page 21 occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 20, 2023, at 9:58 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to residents. R3 R3's diagnoses included dementia with behavior disturbance, depression with anxiety and paranoid schizophrenia (debilitating symptoms that blurs the line between what is real and what isn't, making it difficult for the person to lead a typical life). R3's prescriber orders dated July 5, 2022, included a diabetic, pureed and nectar thick liquids. On March 21, 2023, at 6:58 a.m., the evaluator observed R3 eating a pureed breakfast with nectar thick orange juice. R3's service plan dated July 30, 2021, indicated resident was receiving three meals per day. R3's record did not include evidence of an individualized treatment and therapy plan which included the following: - a specialized diet of diabetic, pureed and nectar thick liquids, - identification of treatment or therapy tasks that would be delegated to unlicensed professional (ULP), and - procedures for notifying the registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 22 services. On March 21, 2023, at 3:15 p.m., LALD/CNS-A stated she was not aware specialized diets were considered a treatment. R4 R4's diagnoses included dementia with behavior disturbance, Pick's disease (a less common type of dementia that affects the frontal lobe and exhibits symptoms such as changes in personality and behavior, and/or difficulties with language), diabetes, and obesity. R4's prescriber orders dated March 16, 2023, included an order for heel protector boots (a medical device usually constructed of foam, gel, or fiber-filling, and is designed to offload pressure from the heel). On March 20, 2023, at 12:39 p.m., the evaluator observed ULP-C and ULP-D to transfer R4 from her wheelchair to her bed. ULP-C and ULP-D provided incontinence cares, placed a wedge behind R4's back to assist her to remain off her back and on her right side, and placed heel protectors on both R4's heels. R4's service plan dated December 19, 2022, lacked a written statement of the treatment services the resident received to include heel protectors. R4s record did not include evidence of an individualized treatment or therapy management plan which included the following: - identification of treatment or therapy tasks that would be delegated to ULP, and - procedures for notifying the RN or appropriate licensed health professional when a problem arises with treatments or therapy services.	01940		

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01940	Continued From page 23 On March 21, 2023, at 3:10 p.m., RN-E stated she had updated R4's record to include wound care therapy but had forgot to update R4s service plan and treatment plan to include the heel protector boots. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated for each resident receiving treatment or therapy services, the facility would prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility would develop and maintain a current individualized treatment and therapy management record for each resident which must contain identification of treatment or therapy tasks that would be delegated to ULP, and procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered	01960		

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01960	Continued From page 24 and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of one resident (R4) with blood glucose monitoring managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia with behavior disturbance, Pick's disease (a less common type of dementia that affects the frontal lobe and exhibits symptoms such as changes in personality and behavior, and/or difficulties with language), diabetes, and obesity. R4's service plan and Treatment/Therapy Management Plan dated December 21, 2022, and March 2, 2023, respectively indicated R4 received blood glucose monitoring twice daily. On March 21, 2023, at 7:22 a.m., the evaluator observed unlicensed personnel (ULP)-C conduct a blood glucose monitoring check on R4 which	01960		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 25 resulted in a reading of 107 milligrams (mg)/deciliter (dL). R4's prescriber orders dated April 22, 2022, included an order for blood glucose monitoring twice daily. R4's electronic medication administration record (EMAR) dated March 1, 2023, through March 21, 2023, directed for blood glucose monitoring to be completed twice daily (7:00 a.m. and 8:00 p.m.) and with specific instructions to notify the physician if blood sugar was less than 70 or above 400 mg/dL. R4's Medication Passing Detail - Blood Sugar report dated February 1, 2023, through February 28, 2023; and R4's MAR dated March 1, 2023, through March 21, 2023, indicated blood glucose checks had been completed twice daily. The following dates/times resulted in a blood glucose level less than 70 mg/dL or greater than 400 mg/dL: - February 4, 2023, at 8:00 p.m. with a blood glucose result of 419 mg/dL - February 8, 2023, at 7:36 p.m. with a blood glucose result of 402 mg/dL - February 11, 2023, at 7:19 p.m. with a blood glucose result of 436 mg/dL - February 12, 2023, at 7:09 p.m. with a blood glucose result of 428 mg/dL - February 19, 2023, at 8:06 p.m. with a blood glucose result of 405 mg/dL - February 27, 2023, at 7:00 a.m. with a blood glucose result of 64 mg/dL - February 28, 2023, at 7:00 a.m. with a blood glucose result of 62 mg/dL - March 1, 2023, at 8:00 p.m. with a blood glucose result of 431 mg/dL - March 3, 2023, at 7:00 a.m. with a blood	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 26 glucose result of 60 mg/dL R4s record lacked evidence the nurse and/or physician had been notified of the low or high blood glucose results on February 8, 11, 12, 27, and 28, 2023; and March 1 and 3, 2023. On March 21, 2023, at 3:07 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staff should be contacting the nurse when the blood glucose results are out of the parameters listed on the EMAR. LALD/CNS-A reviewed R4's record and stated the nurse had not been notified of R4's high or low blood sugar results on the dates/times noted above. The licensee's Blood Sugar Testing - Single Equipment Use policy dated August 1, 2021, directed staff to document the results of the blood glucose reading and notify the registered nurse (RN) of any unusual results. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02350 SS=E	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure three of three residents (R10, R11, R4) were treated with dignity	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02350	Continued From page 27 and respect when unlicensed personnel (ULP)-C administered treatments to R10, R11 and R4 in a public setting. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R10 R10's diagnoses included dementia with behavioral disturbances, diabetes, hypertension (high blood pressure), stroke, and congested heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs). R10's service plan dated January 6, 2023, indicated R10 received services to include blood glucose monitoring. R10's prescriber orders dated February 10, 2023, included an order for blood glucose monitoring to be completed twice daily. On March 21, 2023, at 7:11 a.m., the evaluator observed ULP-C conduct R10's morning blood glucose check in the open dining room with six (6) other residents present. ULP-C did not encourage, offer, or attempt to assist R10 to a private area to perform the blood glucose check. R11	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02350	Continued From page 28 R11's diagnoses included dementia and diabetes. R11's service plan dated February 17, 2023, indicated R11 received services to include blood glucose monitoring. R11's prescriber orders dated February 23, 2023, included an order for blood glucose monitoring to be completed twice daily. On March 21, 2023, at 7:17 a.m., the evaluator observed ULP-C conduct R11's morning blood glucose check in the open dining room with ten other residents present. ULP-C did not encourage, offer, or attempt to assist R11 to a private area to perform the blood glucose check. R4 R4's diagnoses included dementia with behavior disturbance, Pick's disease (a less common type of dementia that affects the frontal lobe and exhibits symptoms such as changes in personality and behavior, and/or difficulties with language), diabetes, and obesity. R4's service plan dated December 19, 2022, indicated R4 received services to include blood glucose monitoring. R4's prescriber orders dated April 22, 2022, included an order for blood glucose monitoring twice daily. On March 21, 2023, at 7:22 a.m., the evaluator observed ULP-C conduct R4's morning blood glucose check in the open dining room with ten other residents present. ULP-C did not encourage, offer, or attempt to assist R4 to a private area to perform the blood glucose check.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	03/21/2023

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02350	Continued From page 29 On March 21, 2023, at 7:26 a.m., directly following the above observations, ULP-C stated she was told it was okay to conduct blood glucose checks in the dining room but "I suppose I should have taken them [residents] back to their rooms". On March 21, 2023, at 3:04 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff have been directed to not do blood glucose checks in the dining room with other residents present. LALD/CNS-A stated blood glucose checks should be conducted in a private area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

Minnesota Department of Health
Food, Pools, and Lodging Services
1505 Pebble Lk Rd, S 300
Fergus Falls, MN 56537
218-332-5160

Type: Full
Date: *03/20/23*
Time: 11:30:04
Report: 1035231047

Food and Beverage Establishment Inspection Report

Location:
Cornerstone Residence Fosston
115 1st Street East
Fosston, MN56542
Polk County, 60

Establishment Info:
ID #: 0037674
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184356333
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40.8 Degrees Fahrenheit - Location: Yogurt
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36.7 Degrees Fahrenheit - Location: Eggs
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36.3 Degrees Fahrenheit - Location: Juice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36.5 Degrees Fahrenheit - Location: Ground Beef
Violation Issued: No

Type: Full
Date: *03/20/23*
Time: 11:30:04
Report: 1035231047
Cornerstone Residence Fosston

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 165.9 Degrees Fahrenheit - Location: Stuffing
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155.1 Degrees Fahrenheit - Location: Carrots
Violation Issued: No

Process/Item: Hot Holding
Temperature: 177.4 Degrees Fahrenheit - Location: Chicken Breast
Violation Issued: No

Process/Item: Hot Holding
Temperature: 159.4 Degrees Fahrenheit - Location: Shredded Chicken
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Things to remember:

1.The certified food protection manager should be routinely conducting self inspections to ensure that employees are following proper food handling practice.

2.Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3.There should be a person in charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4.Employees should use spatula, tongs, deli tissue, gloves or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: *03/20/23*
Time: 11:30:04
Report: 1035231047
Cornerstone Residence Fosston

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1035231047 of 03/20/23.

Certified Food Protection Manager: Michele J. Sander

Certification Number: FM96701 Expires: 12/19/24

Inspection report reviewed with person in charge and emailed.

Signed: Emailed to HRD
Establishment Representative

Signed: Alyssa Schill
Alyssa Schill
Public Health Sanitarian 1
Fergus Falls
218-332-5160
alyssa.schill@state.mn.us