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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BGOQ

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245307**
2.STATE VENDOR OR MEDICAID NO.
(L2) **458430000**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/13/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 01/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/06/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN 24-5307

At the time of the standard survey completed September 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On November 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on November 21, 2013, the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on September 20, 2013 effective October 23, 2013, therefore the remedies outlined in our letter to you dated October 29, 2013, will not be imposed.
See attached CMS-2567B form for the results of the November 13, 2013 and November 21, 2013 revisit.

CCN 24-5307 February 6, 2014

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

Dear Ms. Swanson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 23, 2013 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 23, 2014

Ms. Kari Swanson, Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

RE: Project Number 00974

Dear Ms. Swanson:

On October 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 19, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 23, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 19, 2013, effective October 23, 2013 and therefore remedies outlined in our letter to you dated October 29, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman/BA

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing	11/13/2013

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	Correction Completed 10/17/2013	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 10/17/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 10/17/2013
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 10/17/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 10/17/2013	ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 10/17/2013
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 10/17/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 10/23/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 1/23/14	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/19/2013				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing **01 - MAIN BUILDING**	11/21/2013

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/23/2013**	ID Prefix	Correction Completed **09/23/2013**	ID Prefix	Correction Completed **09/23/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0020		LSC K0025		LSC K0029	
ID Prefix	Correction Completed **10/11/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0062		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By ✓ **State Agency**	**Reviewed By** 10562	**Date:** 1/23/14	**Signature of Surveyor:**	**Date:**
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/20/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing **01 - MAIN BUILDING**	11/21/2013

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/23/2013**	ID Prefix	Correction Completed **09/23/2013**	ID Prefix	Correction Completed **09/23/2013**
Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0029	
ID Prefix	Correction Completed **10/11/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0062		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/20/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BGOQ

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

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2008**

6. DATE OF SURVEY **09/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NE II 11/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/02/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed September 19, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4479

October 29, 2013

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

RE: Project Number S5307023

Dear Ms. Swanson:

On September 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 29, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 29, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by December 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by March 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification	F 000	Date Received 11/7/13 This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 resident (R29) in the sample who voiced a concern related to care and services provided by a nursing assistant. Findings include: R29's admission Minimum Data Set (MDS) dated 9/3/13, indicated R29 was cognitively intact and she required one person assist with bathing, toileting and personal hygiene. On 9/19/13, at 4:55 p.m. R29 was seated in her wheelchair in her room. She revealed she wore a	F 166	R29 was unable to remember which staff made the statement cited in the deficiency. An alternate incontinent product was offered and provided to this resident to promote independence and ability to change the product as desired. The plan of care was updated regarding the resident's wishes with incontinence products. This resident has since discharged. Nursing staff were	10/17/13

OK 11/13/13 SG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kay Swanson — TITLE: Administrator — (X6) DATE: 11-6-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 1 brief and recently one of the nursing assistants helped her in the bathroom. At that time, R29 requested to have her brief changed. The nursing assistant did not change her brief as she instructed R29 that it wasn't wet enough and she could go twice in it before she needed to have it changed. R29 revealed she was unable to identify the nursing assistant; however, she had made this incident known to another staff member. R29's Mood and/or Behavior Observation form dated 9/14/13, revealed the director of nursing (DON) had been notified that R29 had communicated to staff about an incident where she had been told to wear her brief twice after she had urinated in it and the brief hadn't been changed. On 9/19/13, at 9:04 a.m. R29 confirmed no staff member had followed up with her in regards to this incident. On 9/19/13, at 9:42 a.m. DON revealed she had been made aware of this incident and had not followed up personally with the resident. The DON confirmed she should have looked into it more and followed up with the resident. On 9/19/13, at 10:44 a.m. the assistant director of nursing (ADON) confirmed she considered this incident a grievance.	F 166	educated on 10/16/13 and 10/17/13 on the facility's complaint/grievance policy and procedures and resident rights. On 9/25/13, a representative from Tena (incontinence vendor) provided selected staff with education on products. The complaint/grievance process will continue to be implemented for all residents by following the facility's policy and procedures. Documentation and followed up on all complaints/grievances shall be completed as they occur. The Social Services Designee shall complete random resident satisfaction surveys weekly, then quarterly until compliance is achieved and maintained. The Social Services Designee updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for review.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	R36's care plan was updated on 9/20/13 to reflect recommendations	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the written care plan was revised to include the correct tube feeding formula and procedure for 1 of 1 resident (R36) in the sample who was reviewed for tube feeding. Findings include: Review of the most recent physician orders for enteral [delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins] nutrition for R36 dated 9/12/13, identified the following: "Nepro [tube feeding half strength every 2 hours until further update. 75 cc [cubic centimeters] of feeding with 75 cc of water. From 8pm to 8am, update [the residents primary physician] on 9/12/13, on residents status.	F 280	assessed by the Registered Dietician. All residents who receive a tube feeding had plan of cares updated to reflect current need. Nursing staff were educated on updating of the plan of care for all residents on 10/16/13 and 10/17/13. The Director of Nursing shall audit random plans of care on a weekly basis until compliance is achieved. The MDS coordinator shall review plan of care for residents quarterly. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 Review of the dietary assessments revealed an annual nutritional assessment was completed on 5/9/13, by the registered dietician (RD) which identified that the resident received no nutritional by mouth; received 1.2 Jevity (a type of enteral nutrition) 80 milliliter (ml) an hour for 12 hours delivered through a pump; and received 30 ml of a nutritional supplement Prosource every day. Review of the residents care plan dated 8/21/13, included the following: Tube feedings and hydration-H2O [water] via tube as ordered. No medications, food or fluid by mouth-NPO. Hydration assessment done annually reviewed at least quarterly. Monitor labs and weights as ordered per protocol up-date provider and dietary with significant weight changes. Tube feedings off for 4 hrs [hours] per day d/t [due to] medication interactions. Monitor for signs and symptoms of dehydration such as decreased output, foul concentrated urine, constipation, dry oral cavity." The care plan had not identified which feeding tube formula was supposed to be used; had not identified how to mix the feeding and water; had not identified how to provide the Prosource nutritional supplement; had not identified how long the formula was good for after the bottle was opened and if the unused portion of the formula required storage in the refrigerator; and had not identified by what means the enteral nutritional was supposed to be delivered. During interview with the director of nurses (DON) on 9/19/13, at 2:30 p.m. she confirmed that the care plan for R36 had not been revised to include the type, amount, and way of delivery the enteral nutrition was to be provided to the resident.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 282 SS=E	Continued From page 4 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions were followed during dinning to minimize risk of aspiration for 1 of 1 resident (R25) in the sample who was fed using syringes; and the facility failed to ensure that care plan interventions were consistently implemented for restorative nursing for 3 of 6 residents (R52, R41 and R45) reviewed for restorative nursing. Findings include: R25 was not provided assistance with eating according to the care plan. R25 was observed during the noon meal on 9/18/13, at 11:30 a.m. during which it was noted the resident sat in the hallway while the other residents in the nursing home were escorted into the dinning room and provided the noon meal. Licensed practical nurse (LPN)-B then assisted R25 to eat the meal. LPN-B took a large syringe filled it with food from the coffee cups and placed the syringe into the resident's mouth and pushed approximately 10-20 cc (cubic centimeters) of food into the residents mouth from the syringe. At this time R25 was was reclined at about 100 degrees while seated in the wheelchair. It was	F 282 F 282	R25's plan of care was reviewed and noted to be accurate as well as reviewed with nursing staff on 10/16/13 and 10/17/13. The LPN was immediately provided with education after the noted incident in the citation. The Director of Nursing shall conduct audits of dining weekly, then quarterly to ensure each resident is properly positioned in the dining room. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review. R52, R41, and R45's plans of care were reviewed and noted to be accurate. Auditing of the restorative program will be completed by the Assistant Director of Nursing weekly on affected and random residents until compliance is achieved. Quarterly auditing will continue on an ongoing basis. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 noted that LPN-B stood over the resident while she assisted the resident to eat. R25 started the meal at 11:44 a.m. and was finished with the meal by 11:57 a.m. During this observation R25 coughed and her face turned bright red 3 times after food was pushed from the syringe into her mouth at 11:46 a.m.; 11:49 a.m.; and 11:54 a.m. The residents current care plan dated 8/21/13, was reviewed and the following was identified: "Problem: At risk for dehydration, aspiration and nutrition deficit r/t [related to] mechanical altered diet, diuretic use, varied intake throughout the day with resisting foods/fluids at times and dependence on others for intake". Interventions included: "Eats meals in dinning room, dependent on staff, nurse to syringe feed-family aware and allows each food to be placed in individual cups to ease administration of food and decrease mixing of food. Sit up at 90 degree angle when eating. Syringe feed 10-20 cc at each time, if coughing decrease by 5 cc until no longer coughing. Diet: Regular, pureed with honey thickened liquids and syringe fed." LPN-B was interviewed after the meal on 9/19/13, at 12:37 p.m. and was asked who had trained her to feed R25 with syringes and she stated that she could not remember it had been so long ago. LPN-B was asked if she was supposed to stand up when R25 was fed and she stated that she was unable to feed R25 any other way than to stand up over the resident and push the food into her mouth with a syringe. LPN-B confirmed that R25 should have been seated straight up at 90 degrees to minimize the risk for aspiration and confirmed she had not sat R25 straight up in her chair at 90 degrees during the noon meal on 9/18/13.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 During interview with the assistant director of nursing (ADON) on 9/18/13, 12:04 p.m. during which she confirmed that R25 had not been assisted with eating according to the care plan she stated that LPN-B should have sat in a chair next to the resident so they are face to face to make contact and talk to the resident during the procedure. The ADON further stated that the licensed nurse needed to ensure the resident is seated at a 90 degree angle to minimize the risk of aspiration as the care plan identified. R52 did not receive her exercise program consistently two to three times a week as directed by her plan of care (POC). R52's POC dated 8/22/13, indicated she had impaired mobility and balance associated with weakness and compression fracture. R52's POC revealed she was to have a functional maintenance program (exercise program) as recommended by therapy. R52's Restorative Care Program dated, 7/15/13, directed staff to conduct upper body strengthening and endurance exercises two to three times a week; and to maintain ambulation and lower extremity exercises three times a week. R52's Restorative Plan of Treatment sheet revealed the following: · Week of 7/16/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received zero. · Week of 7/28/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 · Week of 8/4/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 8/11/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 8/18/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 9/1/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received one. · Week of 9/8/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received one. On 9/17/13, at 3:12 p.m. assistant director of nursing (ADON) confirmed for the month of September R52 had not been receiving her functional maintenance program two to three times a week as directed. On 9/19/13, at 10:30 a.m. RNA confirmed R52 had not consistently received her exercise sessions as ordered. R41 did not receive her restorative care program consistently two to three times a week as directed by her plan of care. Review of the resident's care plan (POC) dated 8/21/13 indicated R41 had alteration in mobility, self cares and was at risk for falls associated with her past CVA and impaired cognition. The POC indicated R41 was to receive "FMP with restorative 3 x weekly", which is a functional maintenance program (exercise program) from nursing.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 R41's Restorative Care Programs dated 8/29/13 for lower extremity and 9/9/13 for upper extremity directed staff to conduct lower body exercises to maintain strength, standing tolerance and ambulation three times per week and upper body strengthening to maintain her ability to assist with activities of daily living two to three times per week R41's Restorative Plan of Treatment outlined a program for three lower body and two to three upper body exercise program opportunities per week. Treatment sheets revealed the following: For LE: - Week of 9/1/13, R41 received one lower body exercise session. - Week of 9/8/13, R41 received one lower body exercise session. For UE: - Week of 9/10/13, R41 received two upper body exercise sessions, meeting goals. During and interview on 9/19/13 at 9:55 a.m., the restorative nursing assistant (RNA)-A verified R41 had not been seen as outlined by the restorative care program, "If I or the other restorative aide was pulled to the floor, she would not be seen". During an interview on 9/19/13 at 1:34 p.m., the assistant director of nursing (ADON) verified R41 should be getting restorative nursing program three times per week and "that has not happened and should have been". R45 did not consistently receive her restorative care program three to four times a week as directed.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 R45's plan of care (POC) dated September, 2013 indicated R45 had alteration in self cares, mobility and was at risk for falls associated with her pelvic fracture and impaired cognition. The POC did not indicate she was to have a functional maintenance program (FMP), however an FMP per occupational and physical therapy was ordered and outlined on 7/22/13. R45's Restorative Care Program dated 7/22/13, directed staff to conduct upper body strengthening to maintain strength and range of motion 3 times per week, and to maintain lower extremity strength and balance with ambulation and lower extremity exercises three to four times per week. R45's Restorative Plan of Treatment outlined a program for three upper body and three to four lower body exercise program opportunities per week. Treatment sheets revealed the following: - Week of 8/1/13, R45 received one upper body and two lower body exercise sessions. - Week of 8/8/13, R45 received two upper and lower body exercise sessions. - Week of 8/15/13, R45 received no upper or lower body exercise sessions. - Week of 8/22/13, R45 received three upper and lower body exercise sessions. - Week of 8/29/13, R45 received no upper or lower body exercise sessions. - Week of 9/5/13, R45 received two upper and lower body exercise sessions. - Week of 9/12/13, R45 received one upper and lower body exercise session. Quarterly restorative nursing monitoring note dated 8/23/13, revealed R45 participated willingly	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 and continues to receive upper extremity (UE) and lower extremity (LE) active range of motion (ROM) program three times per week for UE and three to four times per week for LE and plan is to continue with current FMP and monitor on a quarterly basis. During an interview on 9/19/13, at 9:54 a.m., RNA-A stated R45 started FMP on 8/1/13 and should have been receiving UE exercise three times per week and LE exercise three to four times per week. RNA-A verified that R45 had not been seen as the care plan outlined and "if it was not charted, it was not done". During an interview on 9/19/13 at 1:27 p.m., the assistant director of nursing (ADON) verified R45 did not receive her scheduled FMP as directed and that R45 would not have refused as she willingly attended the sessions.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure restorative nursing was provided according to the residents assessed needs for 3 of 6 residents (R52, R45 and R41) in the sample reviewed for restorative nursing. R52 did not receive her exercise program	F 311	R52, R41, and R45's plans of care were reviewed and noted to be accurate. Auditing of the restorative program shall be completed by the Assistant Director of Nursing weekly on effected and random residents until compliance is achieved. Quarterly auditing shall continue on an ongoing basis. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11 consistently two to three times a week as directed by rehabilitation services. R52's quarterly Minimum Data Set (MDS) dated 8/11/13, indicated R52 was cognitively intact and required extensive assist with walking, toileting and personal hygiene. R52's plan of care (POC) dated 8/22/13, indicated she had impaired mobility and balance associated with weakness and compression fracture. R52's POC revealed she was to have a functional maintenance program (exercise program) as recommended by therapy. R52's Restorative Care Program dated, 7/15/13, directed staff to conduct upper body strengthening and endurance exercises two to three times a week; and to maintain ambulation and lower extremity exercises three times a week. R52's Restorative Plan of Treatment sheet revealed the following: · Week of 7/16/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received zero. · Week of 7/28/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 8/4/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 8/11/13, R52 had the opportunity for three ambulation and lower body exercise sessions and received two. · Week of 8/18/13, R52 had the opportunity for three ambulation and lower body exercise	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 sessions and received two. · Week of 9/1/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received one. · Week of 9/8/13, R52 had the opportunity for two to three upper body exercise sessions and three ambulation and lower body exercise sessions and received one. Quarterly restorative nursing monitoring note dated 8/13/13, revealed R52 continued to receive upper and lower active range of motion two to three times a week and the plan was to continue with this exercise program and to monitor on a quarterly basis. On 9/17/13, at 3:12 p.m. assistant director of nursing (ADON) confirmed for the month of September R52 had not received her functional maintenance program two to three times a week as directed. On 9/19/13, at 10:30 a.m. restorative nursing assistant (RNA)-A confirmed R52 had not consistently received her restorative nursing exercise sessions as ordered. On 9/19/13, at 10:45 a.m. RNA-A was observed during R52's restorative nursing exercise regime. R52 tolerated the exercise program well; R52 was willing, required minimal cueing to participate, voiced no complaints of discomfort and was allowed adequate rest periods in between exercises. R45 did not receive her restorative care program consistently three to four times a week as directed by rehabilitation services.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13 R45's admission MDS dated 6/26/13, indicated R45 had moderate cognitive impairment and required extensive assistance with transfers, toileting and personal hygiene. R45's POC dated September, 2013 indicated R45 had alteration in self cares, mobility and was at risk for falls associated with her pelvic fracture and impaired cognition. The POC did not indicate she was to have a functional maintenance program (FMP), however a FMP per occupational and physical therapy was ordered and outlined on 7/22/13. R45's Restorative Care Program dated 7/22/13, directed staff to conduct upper body strengthening to maintain strength and range of motion 3 times per week, and to maintain lower extremity strength and balance with ambulation and lower extremity exercises three to four times per week. R45's Restorative Plan of Treatment outlined a program for three upper body and three to four lower body exercise program opportunities per week. Treatment sheets revealed the following: - Week of 8/1/13, R45 received one upper body and two lower body exercise sessions. - Week of 8/8/13, R45 received two upper and lower body exercise sessions. - Week of 8/15/13, R45 received no upper or lower body exercise sessions. - Week of 8/22/13, R45 received three upper and lower body exercise sessions. - Week of 8/29/13, R45 received no upper or lower body exercise sessions. - Week of 9/5/13, R45 received two upper and lower body exercise sessions. - Week of 9/12/13, R45 received one upper and	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 14 lower body exercise session. Quarterly restorative nursing monitoring note dated 8/23/13, revealed R45 participated willingly and continues to receive upper extremity (UE) and lower extremity (LE) active range of motion (ROM) program three times per week for UE and three to four times per week for LE and plan is to continue with current FMP and monitor on a quarterly basis. The FMP was not observed to take place from 9/16/13 - 9/19/13, during the survey period. During an interview on 9/19/13, at 9:54 a.m., RNA-A stated R45 started FMP on 8/1/13, and should have received UE exercise three times per week and LE exercise three to four times per week. RNA-A verified that R45 had not been seen as the care plan outlined and "if it was not charted, it was not done". During an interview on 9/19/13, at 1:27 p.m., the assistant director of nursing (ADON) verified R45 did not receive her scheduled FMP as directed and that R45 would not have refused as she willingly attended the sessions. R41 did not receive her restorative care program consistently two to three times a week as directed by rehabilitation services. . R41's quarterly MDS dated 8/19/13, indicated R41 had severe cognitive impairment and required extensive assistance with bed mobility, transfers, walking and toileting. A care area assessment (CAA) dated 5/21/13, indicated R41 required total to extensive assistance with all	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 15 activities of daily living (ADLs). R41's POC dated 8/21/13, indicated R41 had alteration in mobility, self cares and was at risk for falls. The POC indicated R41 was to receive a functional maintenance program (exercise program) from nursing as recommended by therapy. R41's Restorative Care Programs dated 8/29/13, for lower extremity and 9/9/13, for upper extremity directed staff to conduct lower body exercises to maintain strength, standing tolerance and ambulation three times per week and upper body strengthening to maintain her ability to assist with activities of daily living two to three times per week R41's Restorative Plan of Treatment outlined a program for three lower body and two to three upper body exercise program opportunities per week. Treatment sheets revealed the following: For LE: - Week of 9/1/13, R41 received one lower body exercise session. - Week of 9/8/13, R41 received one lower body exercise session. For UE: - Week of 9/10/13, R41 received two upper body exercise sessions, meeting goals. During and interview on 9/19/13, at 9:55 a.m., RNA-A verified R41 had not been seen as outlined by the restorative care program, "If I or the other restorative aide was pulled to the floor, she would not be seen". During an interview on 9/19/13, at 1:34 p.m., the assistant director of nursing (ADON) verified R41	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 16 should be getting restorative nursing program three times per week and "that has not happened and should have been".	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure interventions were implemented to minimize accident hazards related to aspiration, and the risks and benefits for providing nutrition via a syringe were documented for 1 of 1 resident (R25) in the sample who was fed using a syringe. Findings include: R25 was observed during the noon meal on 9/18/13, at 11:30 a.m. during which it was noted the resident sat in the hallway while the other residents in the nursing home were escorted into the dinning room and provided the noon meal. At 11:44 a.m. R25 was wheeled into the dinning room and was served the noon meal which included; chicken, mashed potatoes and gravy and carrots in several coffee cups with no utensils. Licensed practical nurse (LPN)-B then assisted R25 to eat the meal and took a large	F 323	On 9/20/13, R25's Power of Attorney was updated and educated of the risks and benefits to syringe feeding. Documentation was made in the clinical record, including a waiver for declination of speech therapy and continued use of syringe feeding on 10/11/13, as well as the plan of care updated. A new stool was purchased to ensure staff is seated by the resident while feeding. R25's plan of care was reviewed and noted to be accurate related to how staff should assist the resident during feeding. Licensed staff were re-educated on proper feeding techniques on 10/17/13. The LPN was immediately provided with education after the noted incident in the citation. The Director of Nursing shall conduct	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 syringe, filled in with food from the coffee cups and placed the syringe into the residents mouth and pushed approximately 10-20 cc's (cubic centimeters) of food into the residents mouth from the syringe. The resident was not seated straight up in the wheelchair during this procedure, the resident was reclined at about 100 degrees while seated in the wheelchair. It was noted that LPN-B stood over the resident while she assisted the resident to eat. It was also noted the resident started the meal at 11:44 a.m. and the resident was finished with the meal by 11:57 a.m. During this observation R25 coughed and her face turned bright red three times after food was pushed from the syringe into her mouth at 11:46 a.m.; 11:49 a.m.; and 11:54 a.m. The speech language pathologist (SLP) was in the dinning room during the observation of noon meal on on 9/18/13, at 11:30 a.m. and was interviewed on 9/18/13, at 11:49 a.m. during which she stated that feeding a resident with a syringe is actually forcing a resident to eat and when she sees this technique there are many red flags that occur which include a great risk for aspiration. The SLP stated that she has worked as the SLP in this facility since 2010, and has not been asked to evaluate the resident to consider safer techniques to assist the resident to eat. The SLP stated that she was concerned by the resident coughing during the meal but felt that the resident was able to clear the food bolus from her throat at this point so that aspiration had not occurred. The SLP further stated the resident should be seated straight up at a 90 degree angle in her wheelchair when she ate. LPN-B was interviewed after the meal on 9/19/13, at 12:37 p.m. and was asked who had trained her	F 323	audits of dining weekly until compliance is achieved, then quarterly to ensure continued compliance. This resident is the only resident in the facility who receives feeding in this manner. The Director of Nursing shall observe and ensure all residents are fed in an appropriate manner. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 to feed R25 with syringes. LPN-B indicated she could not remember, it had been so long ago. LPN-B was asked if she was supposed to stand up while feeding R25 and she stated that she was unable to feed R25 any other way than to stand up over the resident and push the food into her mouth with a syringe. LPN-B confirmed that R25 should have been seated straight up at 90 degrees to minimize the risk for aspiration and confirmed she had not sat R25 straight up in her chair at 90 degrees during the noon meal on 9/18/13. The residents current care plan dated 8/21/13, was reviewed and the following was identified: "Problem: At risk for dehydration, aspiration and nutrition deficit r/t [related to] mechanical altered diet, diuretic use, varied intake throughout the day with resisting foods/fluids at times and dependence on others for intake." Interventions included: "Eats meals in dinning room, dependent on staff, nurse to syringe feed-family aware and allows each food to be placed in individual cups to ease administration of food and decrease mixing of food. Sit up at 90 degree angle when eating. Syringe feed 10-20 cc at each time, if coughing decrease by 5 cc until no longer coughing. Diet: Regular, pureed with honey thickened liquids and syringe fed." The residents record was further reviewed and an assessment which included the safety aspects of feeding R25 with syringes was not found in the resident's record. The care plan had identified the resident's legal representative (the residents family) was aware the facility fed R25 with syringes but there was no documented evidence found in the resident's medical record which identified the resident's family had been educated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 of the significant risks associated with feeding a resident with syringes. During an interview with the assistant director of nursing (ADON) on 9/18/13, 12:04 p.m. she stated that R25 had been fed with syringes since 1987 and had been an assist to eat with a regular spoon prior to this time. She stated the resident's record did not include any type of assessment which led to the procedure of feeding the resident with syringes. She confirmed the resident's medical record had not clearly identified the legal representative had been educated on the significant safety risks associated with force feeding a resident with syringes. Additionally, she confirmed that when R25 is fed with syringes the nurse who feeds the resident should sit in a chair next to the resident so they are face to face to make contact and talk to the resident during the procedure. The ADON further stated the licensed nurse needed to ensure the resident is seated at a 90 degree angle to minimize the risk of aspiration.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	R36's care plan was updated on 9/20/13 to reflect recommendations assessed by the Registered Dietician. The resident was evaluated by nephrology on 10/1/13 who was in agreement with the updated nutritional needs. All residents who receive a tube feeding had plans of care updated to reflect current	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nutritional needs were reassessed at the time of a change in enteral nutrition for 1 of 1 residents (R36) in the sample who were reviewed for tube feeding. Findings include: R36's physician orders for enteral [delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins] nutrition dated 9/12/13, identified the following: "Nepro [tube feeding] half strength every 2 hours until further update. 75 cc [cubic centimeters] of feeding with 75 cc of water. From 8pm to 8am, update [the residents primary physician] on 9/12/13, on residents status. Review of the dietary assessments revealed an annual nutritional assessment was completed on 5/9/13, by the registered dietician (RD) which included the following "49 y/o [year old] female is NPO [nothing by mouth] with TF [tube feeding] of 1.2 Jevity [a type of enteral nutrition] 80 ml [milliliters] x 12 hours qd [every day]. Provides 1152 Kcal [kilocalorie] and 52.8 g [grams] protein. Receives 30 ml Prosource qd which provides 100 Kcal and 10 g protein. Total of 1252 Kcal and 62.8 Protein provided via TF qd. Receives 1550 ml water with meds and 250 ml addition water qd for a total of 1800 ml water. Est. [estimated] Calculated needs: 1625 Kcal; 68 g protein; 1700-2040 cc [cubic centimeters] fluid. Good tolerance of TF. 5/5/13, weight 188# [pounds] is a 1% gain past 30 days and 5% gain in 180 days. BMI [body mass index] is 36.5 is obese. Resident with minimal activity. Skin intact. Receives MVI	F 325	need. On 10/17/13, licensed staff were educated on updating of the plan of care and reviewed for current tube feeding protocols/orders for all residents who receive tube feeding. The Director of Nursing shall audit nutritional assessments for the affected resident and randomly on other residents on a weekly basis until compliance is achieved, and quarterly to ensure compliance. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21 [multi vitamin concentrate] and KCL [potassium chloride]. No new recommendations at this time." The resident's nutrition had not been reassessed by the RD after the tube feeding formula had been changed on 9/12/13, to determine if the new orders for tube feeding met the resident's nutritional needs. During an interview with licensed practical nurse (LPN)-B on 9/18/13, at 11:20 a.m. she stated the resident is not fed between the hours of 8:00 a.m. and 8:00 p.m. and the resident is bolus fed every 2 hours for a total of 7 doses (525 cc) for the day. LPN-B stated that she did not know if the change in tube feeding formula met the nutritional needs for R36. During an interview with LPN-C on 9/18/13, at 2:00 p.m. she established that she is the person who took the physician's order for the change in tube feeding formula for R36. She stated she thought the tube feeding of 75 cc of Nepro and 75 cc of water was supposed to be provided every two hours around the clock aside from two hours before and two hours after administration of the medication Dilantin. She also stated that she was not sure if the change in tube feeding formula met the nutritional needs for R36. Review of the nutritional facts on the bottle of Nepro revealed that there were 1.8 calories per cc of tube feeding formula. The resident received 525 cc of formula per day which calculated to be a total of 945 calories a day. Further review of the physician's orders for R36 revealed the resident also received the nutritional supplement Prosource twice a day which provided a total of 200 calories to the resident. The resident's total caloric intake was calculated as 1145 calories a	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 22 day which is well below the residents estimated caloric need of 1625 calories per day. The protein content of the Nepro formula could not be calculated because the bottle of Nepro did not identify the protein content however the bottle did identify the tube feeding formula was a high protein tube feeding formula. A physician's progress note which identified the reasons for a change in tube feeding formula on 9/12/13, was not found in the residents record. The last physician progress note completed for R36 was dated 9/4/13, and identified the following: "...She is on a feeding tube. She also developed significant proteinuria and started having fluid retention, etiology for her proteinuria/nephrotic-type syndrome is not clear in my mind. I reviewed her meds. I did go ahead and start her on prednisone in a tapering dose and she has had a fairly dramatic loss of edema, I am assuming that she has retained her protein better and we will, when we get to the 5 mg dose of prednisone, which will be a maintenance dose, recheck her urine protein..." Review of the most recent lab results in the resident's record dated 8/14/13, identified that the residents albumin was 1.3 grams (G) per deciliter (DL) the reference range is 3.5-5.0 G/DL. The resident's total protein was low at 3.8 milligrams (ml)/DL and the reference range for normal total protein is 6.3-8.2 MG/DL. Review of the residents care plan 8/21/13, included the following: Tube feedings and hydration-H2O [water] via tube as ordered. No medications, food or fluid by mouth-NPO. Hydration assessment done annually reviewed at least quarterly. Monitor labs and weights as	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 23 ordered per protocol update provider and dietary with significant weight changes. Tube feedings off for 4 hrs [hours] per day d/t [due to] medication interactions. Monitor for signs and symptoms of dehydration such as decreased output, foul concentrated urine, constipation, dry oral cavity." Review of the resident nursing progress notes dated 8/9/13, revealed the director of nurses (DON) went to the clinic with R36 and the following progress note was written "...Would initially like to approach improving albumin status since this lab is 1.5 and is most concerning to him [the residents primary physician]. Increased Prosource to BID and will immediately contact dietician." During an interview with the DON on 9/19/13, at 2:30 p.m. she confirmed that R36 had low albumin and protein lab results and the physician had changed the resident tube feeding formula, and the resident's nutritional status had not been reassessed to determine if the resident's nutritional needs were being met. The DON further indicated the certified dietary manager nor the dietitian was notified of the change in the physician order for R36.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	Licensed staff has reviewed the facility's policy and procedures for the disposal of Duragesic patches on 10/17/13. The Director of Nursing shall audit the disposal of Duragesic patches for those residents noted	10/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 24 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure Fentanyl patches were disposed of according to the facility policy for 3 of 3 residents (R17, R19, R43) in the sample who were prescribed a Fentanyl patch. Findings include: During medication storage review on 9/18/13, at 12:50 p.m. licensed practical nurse (LPN)-A revealed the facility's policy and procedure for the removal and disposal of Fentanyl patches were	F 431	residents on a weekly basis until compliance is achieved. The Director of Nursing shall audit the disposal of Duragesic patches for all residents with an order for a Duragesic patch, on a quarterly basis to ensure compliance. The Director of Nursing updated the Quality Assurance Committee on 10/16/13 and shall continue quarterly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 25 for two licensed staff to witness the disposal of the used Fentanyl patch down the sewer and for both staff to sign off in the narcotics log book of the disposal. On 9/18/13, at 12:55 p.m. the narcotics log book revealed and LPN-A confirmed: · R17's Fentanyl patch narcotic log lacked duel witness signatures for destruction of a Fentanyl patch on 9/13/13. · R19's Fentanyl patch narcotic log lacked duel witness signatures for destruction of Fentanyl patches on 8/22/13 and 8/31/13. · R43's Fentanyl patch narcotic log lacked duel witness signatures for destruction of Fentanyl patches on 8/15/13, 8/18/13, 8/21/13, 9/11/13, 9/14/13. On 9/19/13, at 9:36 a.m. director of nursing (DON) and assistant director of nursing (ADON) confirmed the above entries in the narcotics log book lacked a duel witness signature and the facility policy for the destruction of Fentanyl patches was not being followed consistently. The facility's Disposal of Fentanyl (Duragesic) Patch policy/procedure dated 4/11/13, directed staff when disposing of a Fentanyl patch the staff should flush the patch down the sewer in the presence of a licensed nurse and a witness. The destruction and witness of destruction must be documented.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	The carpet in room 114 was cleaned on 10/11/13. A schedule has been created to include the cleaning of all carpeted rooms on a quarterly basis or more frequently if needed. The Maintenance staff has repaired	10/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to resident rooms were maintained in a safe and homelike environment for 5 of 30 residents. In addition, the facility failed to maintain the whirlpool tub on the 200 wing in a clean and sanitary manner. This had the potential to affect 24 residents who resided on the 200 wing. Findings include: During an environmental tour on 9/19/13, at 8:45 a.m. with the maintenance director (MD-A), the following broken and chipped furniture and closets were noted and verified: Room 113A was noted to have wood exposed and chipped off in the lower right side of the closet door to the left of the 3 drawer dresser. Room 114A was noted to have carpet stains in all areas that were not covered by furniture with a heavily soiled area in the door entry. MD-A stated "we clean the carpets about every 2 months or as needed", and further stated, "Yes I see the stains, we need to clean this." Room 115A was noted to have the bottom bed board that measured approximately 3 1/2 feet x 2 feet in length and had a crack with approximately a 1/4 inch gap that extended the entire length of the board. Room 201B was noted to have the lower, middle area of the bottom drawer with a 1/2 inch x 1/2 inch chip out of the wood that exposed a jagged edge.	F 465	any/all rough, chipped, or exposed wood on the closet doors and/or dressers in rooms 113, 201, and 202. The whirlpool tub was thoroughly cleaned on 10/11/13 by Maintenance. The footboard in room 115 was replaced with a new one. Each resident's foot/head board was inspected to ensure it was in good condition, and replaced if necessary. A monthly inspection shall be completed on all rooms to ensure each dresser/closet and beds are in good condition. The Monthly Resident Room Maintenance Checklist has been reviewed and updated to include carpet, furniture and head/foot boards. The Environmental Services shall complete monthly inspections of each room, including the tub room, and address any maintenance needs, to ensure they are maintained in a safe, functional, sanitary, and comfortable environment for the residents, staff and public. The Administrator updated the Quality Assurance Committee on 10/16/13 and shall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 27 Room 202A was noted on the left side of the second dresser drawer to have 1 inch wide x 3 inch long chip out of the wood and the drawer did not close. The right edge of the third drawer had wood exposed with jagged edges that measured approximately 4 inches x 1 inch wide. MD-A stated anyone can request repairs and record it in the "Log Book for Requesting Repairs" binder located at the nurses station. MD-A indicated he checked the log two times per day and recorded the date it was completed, and further indicated he was not aware of any of the concerns noted above. Review of the facility's policy, dated 9/2013, identified staff "to report all repair requests to the maintenance department to ensure the safety of residents, staff and visitors". During an interview on 9/19/13, at 2:41 p.m., the director of nursing (DON) stated anyone who sees necessary maintenance repairs need to record the request in the log book at the nurse's station and then maintenance is responsible to see that it gets done, "everyone should be doing that". The whirlpool tub on the 200 wing was not maintained in clean and sanitary manner. On 9/18/13, at 9:00 a.m. during an interview with bath aide (BA)-C the whirlpool tub on the 200 wing was observed to have a thick white crusty substance three to four inches around the rim of the tub and across the entire water control panel of tub. BA-C stated she thought it was a calcium or mineral build up, she further stated she had tried to use different products, but it did not come	F 465	continue quarterly for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	09/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 28 off. BA-C stated she has talked to MD-A who recommended a product but it did not clean the tub. BA-C verified the tub did not look clean. On 9/18/13, at 1:00 p.m. MD-A indicated some products have been used to try to remove build up, but have been ineffective. MD-A identified he had not talked to a vendor in regards to a cleaning solution for the tub. On 919/13, at 1:52 p.m. the whirlpool bath tub was observed with director of nursing (DON) and BA-C. The DON verified the tub did not look clean and they would look into something to clean the tub.	F 465		

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

F5307021

PRINTED: 10/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cornerstone Nursing and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. POC ok FS 11-8-13	

DUE: 10-29-13

EXIT: 9-19-13

RECEIVED
NOV - 7 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kari Swanson
TITLE: Administrator
(X6) DATE: 11-6-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/20/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. The building is divided into 3 smoke compartments by 30 minute fire barriers. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection is in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have battery operated smoke detectors installed. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code (2007 edition). The fire alarm is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	09/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 43 beds and had a census of 41 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observations and testing it was determined that one of two vertical opening corridor doors are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.1.1. This deficient practice could allow the products of combustion to travel from the lower level into the corridor system if a fire occurs within the chute room, which would negatively impact all 43 of the residents, the staff and any visitors of the facility. Findings include: Observations and testing doors during the facility tour on September 20, 2013, between 8:30 am to 10:00 am, by surveyor 03006, revealed that the main floor chute room corridor door did not completely close and latch. This finding was verified by the Maintenance Man	K 020	The main floor chute room corridor door has been adjusted to completely close and latch. Each month, maintenance shall ensure all smoke barrier doors properly self close while completing the monthly fire drill and sounding of the fire alarm. This shall be documented with each drill. The Environmental Services Supervisor shall be responsible for ensuring compliance thru review each month.	9/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING 01 - MAIN BUILDING B. WING	09/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 020	Continued From page 3 during the facility tour and during the exit conference.	K 020		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations it was determined that two of the two sets of smoke barrier doors are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.7.3. This deficient practice could allow the products of combustion to travel from one smoke compartment to another, which will negatively impact all 49 of the residents, staff and visitors of the facility. Findings include: Observations and testing of the smoke barrier doors during the facility tour on September 20, 2013, between 8:30 am to 10:00 am, by surveyor 03006, revealed that both sets of cross corridor smoke barrier doors did not completely closed when allowed to become self-closing.	K 025	The cross corridor smoke barrier doors have been adjusted to allow for proper self-closing. Each month, maintenance shall ensure all smoke barrier doors properly self close while completing the monthly fire drill and sounding of the fire alarm. This shall be documented with each drill. The Environmental Services Supervisor shall be responsible for ensuring compliance thru review each month.	9/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING 01 - MAIN BUILDING B. WING	09/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 This finding was verified by the Maintenance Man during the facility tour and during the exit conference.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined that two of ten hazardous area corridor doors tested are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which would negatively impact all 43 of the residents, the staff and any visitors of the facility. Findings include: Observations and testing doors during the facility tour on September 20, 2013, between 8:30 am to 10:00 am, by surveyor 03006, revealed that the kitchen doors are being improperly held open, one with a cart and one with a kick down type hold open. (These doors must be on the fire	K 029	On 9/23/13 the kitchen door kick down type holder was removed. The Dietary Supervisor shall be responsible for ensuring compliance of all kitchen doors thru random observations. The Environmental Services Supervisor shall be responsible for ensuring compliance of all fire doors thru observation and with monthly sounding of the fire alarm.	9/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING	**09/20/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 alarm system with local smoke detection to be held open) This finding was verified by the Maintenance Man during the facility tour and during the exit conference.	K 029		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on a review of facility documentation, it was determined that the automatic sprinkler system may not have been serviced in in accordance with NFPA 25 The Standard for Inspection, Maintenance of Water Based Suppression Systems (1999 edition). Failure to properly maintain the automatic fire sprinkler system could affect all 43 of the residents, all staff and any visitors, if the sprinkler system fails to function properly in a fire emergency. Findings include: A review of the automatic fire sprinkler system testing records for Cornerstone Nursing and Rehab by Tyco Simplex/Grinnel, prior to the facility tour on September 20, 2013, at approximately 08:30 am, by surveyor 03006, revealed that the sprinkler system gauges have been replaced or re-calibrated within the past 5 years	K 062	On 10/11/13, Simplex replaced the pressure gauge on the sprinkler system. Annually, the sprinkler system shall be inspected to ensure all pressure gauges are in good working order, and have been replaced or re-calibrated within 5 years. The Environmental Services Supervisor shall ensure this is completed by obtaining the annual sprinkler system inspection report.	10/11/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/20/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 6 This finding was verified by the Maintenance Man during the facility tour and during the exit conference.	K 062		