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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CUH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 23242

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245612**
2.STATE VENDOR OR MEDICAID NO.
(L2) **884696100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX 724**
(L5) **BUHL, MN** (L6) **55713**

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 **10/24/2013** (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)
06/30

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (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
	44			
(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 :
Theresa Ament, HFE NE II 10/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/26/2013 (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
07/16/2004
(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
11/12/2013
(L33)

DETERMINATION APPROVAL

CCN# 245612

At the time of the standard survey completed August 29, 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 October 24, 2013 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 29, 2013, effective October 9, 2013, therefore the remedies outlined in our letter to you dated September 12, 2013, will not be imposed.
See attached CMS-2567B form for the results of October 24, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5612 December 26, 2013

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street, P.O. Box 724
Buhl, Minnesota 55713

Dear Ms. Doughty:

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 9, 2013 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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

October 30, 2013

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street, PO Box 724
Buhl, Minnesota 55713

RE: Project Number S5612011

Dear Ms. Doughty:

On September 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 29, 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 October 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 29, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 29, 2013, effective October 9, 2013 and therefore remedies outlined in our letter to you dated September 12, 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4117

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
245612	A. Building B. Wing	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **10/09/2013**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/01/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0327** Reg. # **483.25(i)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/09/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/09/2013**	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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PH/cbl	10/30/2013	29433	10/24/2013
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
8/29/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 25, 2013

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street Po Box 724
Buhl, MN 55713

Re: Complaint Number H5612007

Dear Ms. Doughty:

A complaint investigation was completed on October 25, 2013. At the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only. Enclosed is the Minnesota Department of Health order form stating that no violations were noted at the time of this investigation.

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.

Please feel free to call me with any questions.

Sincerely,

Kris Lohrke

Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4215 Fax: (651) 281-9796

Enclosure(s)

CC: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CUH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 23242

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245612**

2.STATE VENDOR OR MEDICAID NO.
(L2) **884696100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX**
(L5) **724 BUHL, MN** (L6) **55713**

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)

6. DATE OF SURVEY **08/29/2013** (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)
06/30

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (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
	44			
(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 :
Cynthia Green, HFE Nurs. Eval. II — 10/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Enforcement Specialist — 11/12/2013 (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
07/16/2004
(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
11/12/2013
(L33)

DETERMINATION APPROVAL

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

CCN# 245612

At the time of the standard survey completed July 2, 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 0150 0001 1713 3030

September 12, 2013

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street
PO Box 724
Buhl, Minnesota 55713

RE: Project Number S5612011

Dear Ms. Doughty:

On August 29, 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. In addition, at the time of the August 29, 2013 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5612006.

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 723-4637
Fax: (218) 723-2359

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 8, 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 8, 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 November 29, 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 1, 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.

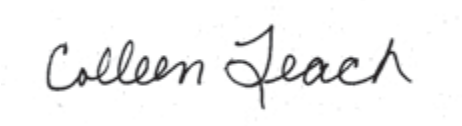
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 09/12/2013
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
	245612	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census 43 An investigation of complaint H5612006 was completed. The complaint was substantiated with deficincies issued at tags F248 and F327.	F 000	OK 10/18/13 PLH 10/19/2013	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		

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

Debra Doughty | Administrator | 9/26/2013

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

TAG F157:
Cornerstone Villa strives to ensure that all changes in a resident's condition and/or status and the plan of treatment are promptly communicated to the resident's physician and family.

Corrective Action:
The family was contacted by the Director of Nursing to determine which family member was to be the facility point of contact as there are several members who share power-of-attorney. This information was listed in the resident chart. The representative was made aware of the treatment for the UTI identified on 8/29/2013.

Corrective Action As It Pertains To Other Residents:
All current residents were reviewed for changes in condition and/or treatment. Those residents identified were reviewed to determine if the physician and family were notified of the change/treatment. Those determined to require notification were notified. This was completed on 9/6/2013. Social Services has talked to all residents and/or representative to determine who needs to be notified of change in condition, treatment and/or injury when there is more than one representative/power of attorney. This will be completed on 10/4/2013.

Changes To Prevent Recurrence:
Notification of change in condition policy and procedure was reviewed and updated on 9/10/2013. This policy and procedure was provided to the licensed nursing staff on 9/10/2013 and was presented at the inservice on 9/27/2013. Upon admission and at quarterly care conference resident and family will be asked about whom to notify if there is more than one representative/power of attorney. This will be documented in the resident medical record.

Monitoring:
The Director of Nursing (or designee) will audit 5 residents weekly who have had a change in condition or treatment (injury, decline, etc) to determine if the physician and designated family member/representative have been notified. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F241:
Cornerstone Villa strives to always promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.

Corrective Action:
The facial hair on Resident R11's face was removed on 8/28/2013. Facial hair removal was added to the bathing task list.

Corrective Action As It Pertains To Other Residents:
All residents were observed for removal of facial hair. Facial hair removal was added to each resident's bathing task list. This was completed on 8/29/2013.

Changes To Prevent Recurrence:
On 8/29/2013 a note was placed in the CNA communication book regarding facial hair removal on all residents per their plan of care. The bathing task list was updated to include facial hair removal. The resident grooming and hygiene policy and procedure was reviewed and presented at the 9/27/2013 staff inservice. On 9/27/2013 all staff will be inserviced on completion of the ADL care plan as well as resident dignity.

Monitoring:
The Director of Nursing (or designee) will audit 3 residents daily to determine if the personal hygiene plan of care is being followed. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/09/2013

TAG F242:
Cornerstone Villa strives to ensure resident right of choice in all aspects of their life in the facility is honored.

Corrective Action:
R7 discharged from the facility on 9/5/2013. R65 discharged on 8/28/2013.

Corrective Action As It Pertains To Other Residents:
All residents were interviewed regarding their current bathing/shower schedule frequency. Residents desiring changes either with time, day, and/or frequency were adjusted on the weekly bathing schedules. This was completed on 9/9/2013.

Changes To Prevent Recurrence:
Upon admission all residents will be asked about their bathing preferences: time of day, day(s) of the week and frequency. A form was developed to document the various residents' preferences (bathing, dining, wake time, etc). Resident preferences will be reviewed with the resident at least quarterly at their care conference. Staff will be inserviced on 9/27/2013 regarding resident's right of choice and their need to communicate preferences to the nurse and to accommodate the resident's request.

Monitoring:
The Social Service Director has developed a report which will be used to track all care conferences and admission which will document all preferences including their bathing preference. The Administrator will review this documentation weekly to ensure that all new admissions and current residents are asked about preferences. The Administrator will choose two from this report weekly to determine if these preferences are being fulfilled. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F248:
Cornerstone Villa provides daily resident activities to meet all residents' needs and interests.

Corrective Action:
Resident R45 died on 9/1/2013

Corrective Action As It Pertains To Other Residents:
All resident activity care plans have been reviewed and updated to ensure residents' needs and interests are being met. Each resident will has an individualized activity care plan. Activity staff were inserviced on 9/24/2013 on providing appropriate daily activities for all residents including those who are cognitively impair and/or who are room bound. All activity care plans were reviewed and updated by 9/20/2013.

Changes To Prevent Recurrence:
Activity care plans will be updated at least quarterly with more frequent adjustments made as resident needs and interests change. The Activity Director will monitor the participation book to determine if a resident is not participating and will investigate the lack of participation. The resident's plan of care will be adjusted to reflect the change and will develop a new plan to meet the resident's needs and interest.

Monitoring:
The Director of Nursing (or designee) will review 3 resident activity care plans weekly to identify if the activities are appropriate and if the resident is participating. All residents who have become room bound will be reviewed for appropriateness of activity plan and participation. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F280:
Cornerstone Villa staff strive to ensure that all resident needs are communicated in their individualized plan of care and that these plans of care are updated as the residents' needs change.

Corrective Action:
Resident R51's plan of care and care sheets were updated on 8/29/2013 to include the fall interventions put into place on 8/13/2013. Resident R45 died on 9/1/2013.

Corrective Action As It Pertains To Other Residents:
All resident care plans have been reviewed and updated to reflect their current needs and interests. The CNA care sheets have been updated to reflect what is in the care plan. This was completed on 9/11/2013.

Changes To Prevent Recurrence:
All changes in care needs will be documented on a change in care flow sheet, CNA care sheets and on the care plan. The night nurse will check the flow sheet for changes and will verify that these changes were made to the care plan. The nurse will update the CNA care sheet prior to printing out the next day's care sheet.

Monitoring:
The Director of Nursing will audit up to 5 resident care related changes weekly and will review both the resident care plan and CNA care sheets to determine if all needed changes have occurred. Social Service Director will audit the activity attendance sheets weekly to identify potential resident activity changes and will review the activity care plan to determine if these changes have been addressed in the plan of care. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F309:
Cornerstone Villa strives to provide the necessary care and services to all residents to ensure they attain or maintain their highest practicable physical, mental and psychosocial well-being.

Corrective Action:
Resident R65 temporary care plan was completed on 8/27/2013 . Resident was discharged from the facility on 8/28/2013.

Corrective Action As It Pertains To Other Residents:
All new resident admissions were reviewed on 9/4/2013 to ensure there was a temporary plan of care completed and CNA care sheets were updated.

Changes To Prevent Recurrence:
Licensed nursing staff were inserviced on 9/4/2013 to review the temporary care plan policy and procedure. All other disciplines were inserviced on 9/4/2013 to review the temporary care plan policy and procedure.

Monitoring: The Director of Nursing will audit all new admissions to ensure that temporary care plans are completed timely by nursing and all other required disciplines. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/1/2013

TAG F312:
Cornerstone Villa strives to ensure that a cares are completed to ensure residents receive the necessary services need to maintain good nutrition, grooming, and personal and oral hygiene.

Corrective Action:
Resident R11's facial hair was removed on 8/28/2013. The care plan was reviewed to ensure that grooming was a part of the individualized plan of care. Staff have been instructed to make sure resident's facial hair is removed during her scheduled bathing time or sooner if needed.

Corrective Action As It Pertains To Other Residents:
All residents were audited to ensure proper facial hair removal. This was completed on 8/29/2013.

Changes To Prevent Recurrence:
Resident grooming policy and procedure was reviewed on 9/3/2013. The policy and procedure was provided and reviewed at the inservice on 9/27/2013.

Monitoring: Social Services Director (or designee) will audit 5 residents weekly for proper facial hair removal per their plan of care and per the policy and procedure. If hair removal did not take place due to refusal, Social Services will review for proper documentation and will continue to monitor for re-approach. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F327:
Cornerstone Villa strives to provide each resident with sufficient fluid intake to maintain proper hydration hand health.

Corrective Action:
Resident R45 died on 9/1/2013

Corrective Action As It Pertains To Other Residents:
Direct care staff care sheets have been revised to include identification of residents requiring assistance who are at risk of dehydration and a section to note if fluid is offered and the volume of fluid intake. Staff were inserviced on the need to offer fluids to all residents requiring assistance and to place fluids within reach of the resident. This was completed on 9/3/2013.

Changes To Prevent Recurrence:
A hydration policy and procedure was developed and will be communicated to all staff at the 9/27/2013 inservice. The care sheets have been revised to include identification of residents who require assistance who are at risk of dehydration and a section to note if fluid is offered and the volume of fluid intake.

Monitoring: The Director of Nursing (or designee) will audit 3 residents daily to ensure that all fluids are placed within reach of the residents, residents requiring assistance are offered fluids during staff cares, nutritional rounds, and by recreational therapy staff during room visits and will review the daily care sheets for intake documentation. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F329:
Cornerstone Villa strives ensure that each resident's drug regiment is free from unnecessary drugs.

Corrective Action:
A behavioral log was implemented on 9/20/2013 for Resident R3 which includes suggestions for non-pharmacological interventions for targeted behaviors. Based on the outcome of the behavior monitoring, the resident will be assessed for continued use of the Seroquel with the goal being reduction if no contraindications of such reduction/discontinuation exist.

Corrective Action As It Pertains To Other Residents:
All residents currently receiving antipsychotic medication (with the absence of a specific condition diagnosed and documented in their clinical record) have had a behavior log implemented. Each log contains suggestions for non-pharmacological behavioral interventions for the targeted behaviors. Unless clinically contraindicated, these residents will receive gradual dose reductions with the goal being discontinuation of the antipsychotic medication unless contraindicated. These logs were implemented on 9/20/2013. The Director of Nursing, Pharmacy Consultant, and Physician will review the logs and the outcome of the non-pharmacological interventions to assess if a medication reduction/discontinuation would be appropriate or clinically contraindicated. This assessment will be completed and documented quarterly thereafter.

Changes To Prevent Recurrence:
A policy and procedure has been developed for continued use of antipsychotic medications which includes the implementation of an individualized behavioral log and suggestions for non-pharmacological interventions for targeted behaviors. The Pharmacy consultant will review the behavior logs and the effectiveness of non-pharmacological interventions monthly and will meet with the Director of Nursing to assess the need for ongoing antipsychotic medication use with the goal being reduction/discontinuation unless contraindicated.

Monitoring: The Director of Nursing will audit all resident behavior logs weekly to ensure proper documentation and effectiveness of non-pharmacological interventions. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

TAG F441:
Cornerstone Villa has developed an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Corrective Action:
On 8/28/2013 resident R59 was placed on infectious disease precaution which included contact precautions, proper housekeeping/sanitation per the policy and procedure. These precautions were in place until 9/10/2013 at which time 3 lab tests dated 8/30, 9/4, and 9/6 resulted in negative for C-diff and resident was not symptomatic.

Corrective Action As It Pertains To Other Residents:
All resident's charts were reviewed for lab results containing positive testing for infectious diseases. There were no other positive lab tests as of 8/30/2013.

Changes To Prevent Recurrence:
The infectious disease policy and procedure was reviewed and presented to all nursing staff by 8/30/2013. The policy and procedure was communicated to all staff at the inservice on 9/27/2013.

Monitoring: The Director of Nursing (or designee) will review all new admissions to determine if there is a need to infectious disease precautions and to determine if the precautions put into place are per the policy and procedure. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.

Completion Date: 10/9/2013

FOREST HEALTH SERVICES

PO Box 724
1000 Forest Street
Buhl, MN 55713

Phone #: 218-258-3253
Fax #: 218-258-8767

Date: 9/26/13 PAGE: 1 of 12

TO: MN Dept of Health

ATTENTION: Pat Halverson 218-723-2359

FROM: FOREST HEALTH SERVICES
dba/CORNERSTONE VILLA Deb Doughty

THE INFORMATION HEREWITH IS STRICTLY CONFIDENTIAL.

MESSAGE:

Pat, attached is Cornerstone Villa's Plan of Correct - Please let me know if you have any questions/Concerns -

Thanks,
Deb Doughty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**08/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	**1000 FOREST STREET PO BOX 724 BUHL, MN 55713**

(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 Surveyor: 03005 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cornerstone Villa, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Cornerstone Villa is a one story building with no basement. It was constructed in 2004/2005. The construction type was determined to be Type V (111). The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 44 beds, the census was 43 at the time of inspection. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S & C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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

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	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**08/27/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	**1000 FOREST STREET PO BOX 724 BUHL, MN 55713**

(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 met.	K 000		