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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GNCY

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 **11/07/2014** (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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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):

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 11/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/19/2014 (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
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
Posted 12/22/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/07/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245612

November 11, 2014

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street Po 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, November 7, 2014 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.

ou 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 11, 2014

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

RE: Project Number S5612012

Dear Ms. Doughty:

On October 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 25, 2014 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On November 7, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 25, 2014, effective November 7, 2014 and therefore remedies outlined in our letter to you dated October 8, 2014, 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

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	11/7/2014

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 **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **11/07/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/07/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/07/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **11/07/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/07/2014**	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PLH/mm	**Date:** 11/11/2014	**Signature of Surveyor:** 12835	**Date:** 11/07/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/25/2014

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GNCY
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: **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 **09/25/2014** (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):

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 10/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/07/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
Posted 11/07/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 8, 2014

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

RE: Project Number S5612012

Dear Ms. Doughty:

On September 25, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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>Electronic 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;

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

<u>Informal Dispute Resolution</u> - 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) 302-6151
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 November 9, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 25, 2014 (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 25, 2015 (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 an ePoC 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

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 _____	09/25/2014

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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		
F 155 SS=D	Census: 38 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		11/7/14

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

Electronically Signed | 10/17/2014

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
	245612	A. BUILDING _____ B. WING _____	09/25/2014

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 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the risks and benefits of refusing range of motion (ROM) rehabilitation services were addressed and documented for 1 of 3 resident (R13) reviewed for ROM services. Findings include: R13's Admission Record dated 4/23/14, indicated R13 had diagnoses that included paralysis agitans and generalized osteoarthrosis. R13's quarterly Minimum Data Set (MDS) dated 8/2/14, indicated R13 was cognitively intact and had functional impairment of both upper extremities. The MDS indicated R13 was not on a restorative nursing program for ROM or splint/brace assistance. R13's Care Plan dated 4/30/14, indicated R13 refused to participate in PT/OT [physical therapy/occupational therapy] evaluations. The Occupational Therapy Discharge note dated 7/3/14, indicated R13 was referred to restorative nursing for ROM of upper extremities and neck. The note also indicated R13 did not want to use a splint/orthosis and noted minimal change with upper extremity ROM. The Cornerstone Villa Restorative Care Plan sheets dated July 2014, August 2014 and	F 155	Therapy attempted ROM rehabilitation screening for R13 on 9/29, 10/6, 10/14, 10/15. R13 refused screening attempts and demanded therapy staff leave room. R13 is not allowing any discussions addressing risks and benefits or rehabilitation services. These attempts for screens and addressing of risks and benefits were attempted by various staff. Therapy staff will continue to attempt screening, services, and discussion of risks/benefits and will continue to document attempts. All residents were screened for their need of rehabilitation services. This was completed on 10/17/2014. Residents screened as benefitting from nursing rehabilitation services were entered into a log in the therapy department as well as in the unit restorative log. Resident Right to Refuse Care/Treatment is reviewed and provided in written form during the admission process via both the Admission Agreement and the Resident Bill of Rights. All resident refusing care/services will be advised of the risks associated with the refusal of care/services and the benefits associated with the care/service. The addressing of the risks and benefits will be documented in the resident's medical record and/or	

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F 155	Continued From page 2 September 2014 directed staff to walk R13 as much as tolerated or provide ROM to lower extremities. The Care Plan sheets did not direct staff to provide upper extremity or neck ROM for R13. On 9/23/14, at 3:56 p.m. R13 was observed resting in bed, awake and alert. His left hand was observed to be contracted and without a splint. On 09/24/2014, at 7:29 a.m. R13 was observed up and dressed seated in a wheelchair at a table in the dining room. No splint was observed to R13's left hand contracture. On 09/23/2014, at 3:56 p.m. R13 stated he used to have therapy to his left hand but stated they stopped that because, "It wasn't any use". R13 also stated he used to wear a splint but did not wear one any longer. On 09/24/2014, at 2:30 p.m. nursing assistant (NA)-E stated R13 ambulated everyday around the loop or to supper. She stated R13's left hand and upper extremity were very stiff and they did not do anything with this. NA-E further stated therapy staff put the restorative sheets together for the restorative aides to follow. On 09/24/2014, at 2:37 p.m. Certified Occupational Therapy Aid (COTA) confirmed the therapy department put together the restorative sheets. COTA also confirmed the OT discharge note indicated a restorative nursing program including ROM of R13's upper extremities and neck was recommended. COTA stated she screened R13 for OT and he had no decline in his upper extremity ROM. Rehabilitation Screen forms dated 7/30/14, 8/21/14, and 9/23/14 were	F 155	therapy notes. A Resident Right to Refuse Care Risk/Benefit policy and procedure was developed on 10/1/2014. On 10/3/2014 Licensed Nurses,Therapy Staff, and Department Managers were inserviced on the policy and procedure addressing the Resident's right of refusal of care/services and the addressing of the risks and benefits with the resident/representative of such refusals. Therapy staff will audit weekly the restorative logs for completion of restorative therapy services and the refusal of recommended services. Therapy will address the risks and benefits with residents refusing recommended services. The DON (or designee) will audit the restorative logs weekly for refusals and corresponding addressing of risks and benefit statement/documentation. The results of these audits will be discussed weekly with the Administrator and at least two quarterly quality assurance committee meeting. The QA committee will determine if these audits will be increased, decreased, or discontinued.	

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F 155	Continued From page 3 reviewed and indicated no decline in ROM. COTA stated R13 had refused any services, braces or washcloths in his hands and she was focused on R13 being able to use a walker as ambulation was important to R13. On 9/25/14, at 8:05 a.m. COTA indicated the restorative recommendations made by the Occupational Therapist were never implemented due to R13's refusal to participate. COTA confirmed there was no documentation in the record of education regarding risks versus benefits related to the ROM to the upper extremities. The Risk/Benefit Policy dated August 2013 indicated residents who refused to participate in goals outlined in the resident's plan of care would be advised by nursing and/or therapy staff of the risks associated with their refusal and advised of the benefits of following the plan of care. The policy also indicated if the resident continued to refuse participation in the plan, it would be documented in the resident's medical record.	F 155		
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:	F 323		11/7/14

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F 323	Continued From page 4 Based on observation, interview, and document review, the facility failed to document follow-up assessments related to falls for 1 of 3 residents (R26) reviewed for falls. Findings include: On 9/23/14, at 8:59 a.m., R26 was observed to have a bruise under the right eye. R26 stated, "I fall, that's me. I have a mat on the floor." There was an alarm on the back of the wheelchair attached to the back of R26's shirt. The wheelchair had auto-lock brakes. R26's face sheet revised 2/24/14, included diagnoses of muscle weakness, sciatica, lupus, abnormality of gait, hypertension (high blood pressure) and anemia (low iron). The history and physical dated 2/23/14, indicated a diagnosis of atonic bladder (flaccid bladder that fails to empty). The annual Minimum Data Set (MDS) dated 9/1/14, indicated R26 had moderate cognitive impairment (memory loss), displayed no mood or behavior problems, had a balance deficit, decreased range of motion (ROM) of one lower extremity, and a history of falls. R26 required extensive assist of one staff for toilet use, dressing, and bathing; limited assist for bed mobility, transfers, ambulation, locomotion in the wheelchair, and personal hygiene. R26 was occasionally incontinent of bladder. R26 received physical therapy from 5/22/14 through 6/6/14 for ambulation, transfers and improved balance to decrease the risk of falls. Physical therapy notes indicated R26 had poor standing balance, a right foot drop, a history of	F 323	A new fall assessment was completed for R26 on 9/26/2014 as well as review of past falls, current interventions, and post fall analysis. New interventions were initiated. Occupational Therapy services initiated on 10/9/2014. Resident was seen by a Certified Orthotist for review of ankle/foot brace. Orthotist recommended new shoes prior to resident wearing brace. Family contacted to purchase new shoes. Resident has agreed to try wearing brace. When new shoes arrive PT will evaluate for therapy services to work on safe transfers and walking. All current resident with falls in the past 30 days were reviewed by the Fall IDT team. Post fall follow-up was initiated per the Fall Prevention Policy and Procedure. Residents experiencing 2 or more falls in the past 30 days will have a new fall assessment completed - residents assessed to be at high risk will be reviewed weekly for effectiveness of interventions. Residents experiencing 3 falls in a month will have a fall monitoring log completed to monitor for patterns. These logs will be reviewed weekly for effectiveness of intervention and to initiate other interventions if identified. Residents identified as at high risk will be reviewed weekly by the fall IDT team for 4 weeks or until resident has not experienced any falls for at least 30 days. This will be completed on 10/17/2014. On 9/26/2014 the Fall Prevention Policy and Procedure was reviewed. On 10/3/2014 Licensed Nurses and the Fall	

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F 323	Continued From page 5 falls, and was not willing to wear the recommended ankle brace. A restorative program was initiated for ambulation with the right ankle brace because R26 walked with greater ease and had a decreased fall risk using the brace. R26's nursing notes on 6/9/14, indicated emergency room evaluation of severe left thigh pain. The diagnoses was myalgia. On 6/11/14, a physical therapy evaluation determined R26 was at baseline, did not need further therapy, and referred for restorative ambulation. R26's incident reports indicated the following: On 6/17/14, at 8:45 a.m. R26 was found on the floor between the bathroom and the bed. R26 told staff she was there and didn't know what happened, so, "Stop asking!" The incident report indicated R26 had been checked and was sound asleep at 7:05 a.m. The intervention was to apply the ankle brace first thing in the morning and leave it on until bedtime. Nursing notes on 6/17/14, at 9:03 a.m., indicated R26 stated she fell in the bathroom and scooted herself over to turn on the call light. Vital signs were done, but not neurological assessments. On 6/22/14, at 12:30 a.m. R26 was found kneeling next to the bed, stating she went into the bathroom without the wheelchair, fell in the bathroom and crawled out to the bed to put the call light on. There were no documented vital signs or neurological assessments. R26 was crying and verbalized depression. The physician was faxed to increase antidepressant dose. There was no evidence of follow-up or assessment of causative factors.	F 323	IDT teams were inserviced on the Fall Prevention Policy and Procedure as well as on accurately completing the fall report/investigation, initial interventions and post fall analysis. Unlicensed Nursing staff were inserviced on 10/9/2014 on the Fall Prevention Policy and Prodedure as well as fall reporting/investigation and interventions. IDT team will review all falls daily (Monday-Friday)for adequate interventions and to initiate post fall follow-up. All Fall reports, investigations, follow-up, and post fall analysis per the policy will be audited by the Administrator and/or the DON weekly. The results of these audits will be presented and discussed at future QA meetings. During the second quarterly QA meeting following completion of the plan of correction the committee, based on the audits, will determine if the audits will be continued or discontinued.	

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F 323	Continued From page 6 On 7/5/14, at 2:15 a.m. R26 was found sitting on floor next to the bed. The call light was on and there was urine in the toilet. The report indicated R26 was asleep at 11:00 p.m. rounds; offered toileting on the second round, and fell before third round. R26 was re-educated on the importance of using the call light before getting up. Neurological assessments were not completed. The documentation lacked follow-up condition documentation. On 7/9/14, at 4:35 a.m. R26 was found sitting on the floor in the bedroom. R26 did not remember how she fell but thought she was on the way to the bathroom. The note indicated R26 was upset about falling. R26 had bare feet and had a large bump on the right temple area. Neurological assessments were done and an ice pack was applied. Slipper socks were applied and R26 was assisted into the bathroom. R26 had been toileted on second rounds, refused on third rounds, and was sleeping when checked at 3:30 a.m. The care plan revised 7/9/14, indicated R26 was at high risk for falls due to weakness, confusion, and falls. Interventions included bed in low position when in bed and a floor mat next to bed, night shift to toilet at 3:30 a.m. in addition to every 2 hour rounds, auto locking wheelchair brakes, brace on when up, wear non-skid footwear when up, and encourage/remind to use the call light. The care plan also indicated R26 required limited staff assistance of one to use the toilet, for transfers, ambulation with a walker, and bed mobility. On 7/15/14, at 8:00 a.m. R26 was found sitting on the floor between the wheelchair and the closet.	F 323		

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F 323	Continued From page 7 R26 stated she was reaching to hang up a sweater. The personal alarm was applied. Neurological assessments were not completed. The falls team meeting notes to determine root cause analysis and appropriate interventions were blank. On 8/23/14, at 5:25 a.m. R26 was found on the mat beside the bed. R26 stated attempting to go to the bathroom although the wheelchair was already in the bathroom. Neurological assessments were not completed. R26 was repositioned at 3:00 a.m. and toileted at 3:35 a.m.; toileted at 5:00 a.m. and fell 25 minutes later. R26 had removed the personal alarm three times between 2nd and 4th rounds during the night. The fall risk assessment dated 9/1/14, indicated R26 had falls, was receiving medications that could contribute to falls, and was frequently incontinent. The analysis indicated R26 was high risk for falls due to loss of balance while standing, required assistance for transfers, attempts to self-transfer, changes in gait pattern when walking through doorways, lurching, swaying, or slapping gait, forgets to use the walker, had poor safety judgement and impaired cognition. On 9/4/14, at 12:45 a.m. R26 attempted self transfer to use the toilet and fell onto the floor mat. R26 denied hitting head, but had a noticeable goose egg developing on the outside of the right eye. Cold was applied. R26 also reported falling on the left leg, where a bruise and light abrasion were noted. There was no documented evidence of neurological assessments or and other follow up to the fall.	F 323		

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F 323	Continued From page 8 The Care Area Assessments (CAAs) for falls dated 9/15/14, indicated R26 was at risk for falls due to instability, history of falls, and antidepressant use. The CAA further indicated R26 was unable to stabilize herself when standing up or transitioning between surfaces, transferring on and off the toilet and while walking with staff. R26 did not call for assistance when getting up and was falling during the night. A 3:30 a.m. toileting was added in addition to every two hour toileting during the night. R26 was refusing the right leg brace. The goal was no serious injures related to falls. The CAA for ADL function indicated R26 was frequently incontinent of urine and required extensive assist of one for toilet use. The CAA for cognitive loss dated 9/11/14, indicated R26 had a decline in cognition, required assist with decision making, but was able to make needs known. The urinary incontinence CAA dated 9/15/14, indicated R26 was frequently incontinent, staff were to offer and assist to bathroom every 2 hours and as needed. The director of nurses (DON) interviewed on 9/24/14, at 2:50 p.m., stated a nursing assessment, ROM check, and notification of family/physician were to be completed for all resident falls. For an unwitnessed fall where staff don't know if the resident hit their head, neurological checks were required. The DON verified neurological checks should have been completed when R26 had a bump near the eye. The DON verified there was no facility guideline for documented follow-up of the resident condition following a fall. The DON stated that any team follow up to falls would be documented on the incident report if completed. R26 was interviewed on 9/25/14, at 9:17 a.m..	F 323		

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F 323	Continued From page 9 R26 talked about previous incidents but not the most recent fall. When refocused on current incidents, R26 stated weakness and losing control was the reason she fell. "I try to get up and do things and I fall." R26 stated awareness of the risk of injury with falls. R26's family member (F)-A, interviewed on 9/25/14, at 2:38 p.m., stated the falls were due to foot drop. F-A verified awareness of the risk of injuries to R26 from falls. During an interview on 9/25/14, at 10:58 a.m. the DON stated consideration had been given to R26's fall pattern during the night and added an extra toileting at 3:30. The DON verified the lack of assessment related to voiding patterns. The DON stated F-A did not agree with a suggested urology consult. F-A was aware of the risk of injury to R26 with ongoing falls. The facility policy and procedure for fall prevention revised 7/13, indicated a "Post Fall Analysis" will be completed after each fall and all falls will be reviewed by an interdisciplinary team during their daily meeting but no less than twice per month to review interventions and look for facility patterns. The facility policy and procedure for neurological assessment revised 2/14, directed neurological assessments are indicated following an unwitnessed fall and following a fall or other accident/injury involving head trauma or when indicated by resident's condition.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		11/7/14

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F 329	Continued From page 10 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide provide side effect monitoring for anticoagulant medications for 2 of 5 residents (R10, R24) reviewed for unnecessary medications. Findings include: R10 was observed on 9/24/14 at 9:19 a.m., with a purple bruise on the right forearm.	F 329	Both R10 and R24 were reviewed for negative side effects of their prescribed anticoagulant on 9/25/2014. No negative side effects were noted for R24 and no additional side effects noted for R10. On 9/25/2014 the MAR was updated to include the side effect monitoring for both R10 and R24 anticoagulant medication. All current Residents' receiving anticoagulant medication will be updated	

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F 329	Continued From page 11 R10's Anticoagulation Clinic Communication form dated 9/23/14, included orders to hold the Warfarin (Coumadin, a medication used to thin the blood) on 9/23/14 and 9/24/14 and give 0.5 milligrams (mg) on 9/25/14. R10 had bruising on the back of the calves that appeared after three days (9/13/14-9/15/14) of Lovenox (injectable anticoagulant medication). R10 was admitted on 7/5/11, and the Admission Record updated for 9/25/14, indicated diagnoses that included, deep vein thrombosis (blood clot), dysarthia (a motor speech disorder), depression and dementia without behavioral disturbance. The quarterly Minimum Data Set dated 8/29/14, indicated R10 was cognitively intact and was receiving an anticoagulant (blood thinner) medication. Monitoring for potential adverse effects of anticoagulant therapy were not addressed on R10's care plan with a print date of 3/25/14, or on the electronic medication record (EMR) and treatment record (TAR) dated 8/1/14, through 9/23/14. On 9/25/14, at 3:30 p.m. the director of nursing (DON) verified the Coumadin monitoring was not on the care plan as it should have been. R24 was receiving Coumadin without monitoring for potential adverse effects. R24's Admission Record printed 9/25/14, indicated diagnoses that included atrial fibrillation and long term use of anticoagulants. The admission Minimum Data Set (MDS) dated 7/24/14, indicated R24 was cognitively intact and	F 329	to include side effect monitoring on their MAR. All current residents' MARs will be update to include instruction to monitor side effect monitor of all medications. Both the AM and PM nurse will monitor side effects daily and will initial accordingly. All side effects will be immediately reported to the Nurse Supervisor and to the Physician. Facility Physician Standing Orders will be update to include direction for monitoring and reporting of medication side effects. This will be complete by 10/24/2014. Documentation System Policy and Procedure was reviewed. A Medication Side Effect Monitoring Policy and Procedure was developed. All Licensed Nursing Staff were inserviced on 10/3/2014 on both Policies and Procedures. All new admission MARs will include side effect monitoring. The DON (or Designee) will audit 6 residents weekly for side effect monitoring and reporting; all new admission MARs will be audited for inclusion of side effect monitoring. These audits will be reviewed and discussed at the next two QA quarterly meetings. At the second QA meeting the committee will determine if these audits will be increased, decreased, or discontinued.	

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F 329	Continued From page 12 was receiving anticoagulant medication. The Consolidated Orders (Chart) Report dated 9/23/14, identified R24 received Coumadin 1.5 milligrams (mg) by mouth daily. Monitoring for potential adverse effects of Coumadin was not addressed on the care plan dated 7/28/14, or on MAR/TAR dated 8/1/14 through 9/23/14. On 9/24/14, at 9:22 a.m. R24 was observed seated in her wheelchair, in her room, wearing a short sleeved night gown. Her demeanor was calm and her skin was observed to be intact without bruising noted to her arms, hands, or legs. On 9/25/14, at 3:16:14 p.m. registered nurse (RN)-B confirmed side effect monitoring for Coumadin was not addressed in the care plan. On 9/25/14, at 5:08 p.m. the DON stated the only monitoring for Coumadin use was INR (international normalized ratio) testing (laboratory measurement used to determine the effects of oral anticoagulants on blood clotting). DON confirmed nothing was formally documented on the care plan directing staff to monitor for potential side effects of Coumadin use. The Anticoagulation-Clinical Protocol dated April 2007 indicated the staff would monitor for possible complications in individuals who were being anticoagulated. The protocol identified if individuals on anticoagulation therapy showed signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse would discuss the situation with the physician before the next	F 329		

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 _____	09/25/2014

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

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F 329	Continued From page 13 scheduled dose of anticoagulant was given.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 356	On 9/26/2014 a Nurse Staffing Hours	11/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 14 review the facility failed to ensure the staff nurse posting included the actual hours worked by licensed and unlicensed direct care nursing staff. This has the potential to impact all 38 residents residing in the facility. On 9/22/14, at 1:05 p.m. the nurse staff posting was located on the bulletin board in the entrance hallway. The nurse staff posting lacked the actual hours worked by licensed and unlicensed direct care nursing staff. On 9/24/14, at 8:20 a.m. the nurse staff posting was located on the bulletin board in the entrance hallway. The nurse staff posting lacked the actual hours worked by licensed and unlicensed direct care nursing staff. During an interview on 9/24/14, at 3:00 p.m. the director of nursing (DON) verified the nurse staff posting did not include the actual hours worked by licensed and unlicensed direct care nursing staff. The facility was unable to provide a policy and procedure for the nurse staff posting.	F 356	Posting policy and procedure was developed. This policy and procedure was inserviced to nursing staff on 10/3/2014 and 10/9/2014 as well as Business Office and Social Services on 9/26/2014. The nurse staffing hours posting will be completed by nursing staff prior to the beginning of each work day which will accurate reflect staffing hours for that given day. This posting will be displayed on the front lobby information board above the Survey Book. These reports will be retained for a minimum of 18 months. Social Services (or designee) will audit these reports 3 times per week to ensure they are completed timely and accurately. The results of these audits will be reviewed and discussed at the next two QA quarterly meetings. During the second QA meeting the committee will determine if the audits will increase, decrease or be discontinued.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		11/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 15 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene was followed and reusable equipment was properly cleaned during a dressing change for 1 of 1 resident (R24). Findings included: On 9/24/14, at 9:22 a.m. registered nurse (RN)-B	F 441	On 9/26/2014 and 10/3/2014 Licensed Nurses were inserviced on the infection control procedures used during dressing changes; which included proper hand hygiene, gloving, handling of dressings, and equipment sterilizing. The DON (or Designee) will directly observe a minimum of two dressing	

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F 441	Continued From page 16 was observed to enter R24's room and wash her hands. LPN-B entered R24's room, carrying dressing change supplies in a pink basin, and washed her hands. R24 was observed seated in a wheelchair with her right foot bare and a stocking to her left foot. R24 stated she had removed the dressing from her right foot prior to their entrance. RN-B removed R24's left stocking and donned gloves. LPN-B placed a disposable absorbent pad with a waterproof backing on the floor, under R24's feet, and donned gloves. RN-B measured the wound to the underside of R24's right foot at the metatarsal head of the great toe and stated it was 0.5 cm x 0.8 cm. RN-B held R24's foot aloft while LPN-B cleansed the wound using a wet wash cloth and baby shampoo. LPN-B dried the wound with a towel and removed and discarded her gloves into the bedside garbage can. No hand hygiene was observed. LPN-B then retrieved a scissors from her pocket and donned clean gloves. LPN-B opened an 8 x 8 inch Mepilex (antimicrobial foam) dressing and cut off a portion of the dressing to cover the size of the wound, using the scissors without cleansing them prior to use. LPN-B returned the scissors to her pocket and applied the Mepilex dressing to the wound. LPN-B then removed her gloves, opened a gauze bandage roll and wrapped the gauze around R24's right foot. LPN-B retrieved the scissors from her pocket, cut the gauze bandage, and returned the scissors to her pocket, without cleansing prior to use. LPN-B opened a package of Coban (self-adherent elastic wrap that functions like a tape) and wrapped it around R24's right foot to secure the gauze bandage. LPN-B retrieved the scissors from her pocket, cut	F 441	changes per nurse. These observations will encompass proper hand hygiene, gloving, and equipment sterilization before, during, and after the procedure. Each nurse will be directly observed until each has demonstrated a minimum of two dressing changes in which proper infection control procedures are demonstrated during each dressing change. This will be completed by 10/24/2014. The DON (or Designee) will audit/directly observe six dressing changes weekly (alternating between shifts) to ensure that proper infection control procedures are used. If any deviations from the policy/procedure occur the nurse will be re-trained and will be required to return demonstrate a minimum of two procedures until proper infection control procedures are return demonstrated. The results of these audits will be reviewed and discussed at the next two QA quarterly meetings. The QA committee will determine at the second meeting if these audits will be increased, decreased, or discontinued.	

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F 441	Continued From page 17 the Coban and returned the scissors to her pocket. LPN-B returned the Mepilex, gauze and Coban dressings to the basin. RN-B removed and discarded her gloves into the bedside garbage can. RN-B washed her hands. LPN-B discarded the absorbent pad into the bedside garbage and bagged the soiled washcloths. RN-B applied alcohol based hand sanitizer and left the room. LPN-B washed her hands and left the room with the soiled, bagged washcloths, basin with dressing supplies, and baby shampoo. She placed the soiled linen in the soiled utility room and returned to the med cart with the basin and the baby shampoo. LPN-B then donned gloves and wiped off the baby shampoo with an alcohol wipe, returned it to the basin, discarded her gloves into the medication cart trash can and put the basin away in the medication room. On 09/24/2014, at 9:43 a.m. LPN-B confirmed did not wash her hands or use hand sanitizer after cleansing the wound and before applying new gloves and confirmed she should have done so. LPN-B also confirmed that she put the used scissors back in her pocket and did not clean them after use and had not cleaned them prior to use. LPN-B stated she usually cleaned her scissors with alcohol wipes after she had used them. On 09/25/2014, at 5:18 p.m. director of nursing (DON) confirmed hand hygiene should have been completed after cleansing the wound and prior to applying clean gloves. DON also confirmed the scissor should have been cleaned with a sani-wipe prior to use.	F 441		

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	245612	A. BUILDING _____ B. WING _____	09/25/2014

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F 441	Continued From page 18 The Dressings, Dry/Clean policy dated June 2005, directed staff to wash and dry hands thoroughly prior to opening clean dressing packages and donning clean gloves. The Wound Care policy dated April 2009 directed staff to wipe reusable supplies such as scissor blades with alcohol prior to use.	F 441		

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 _____	**09/23/2014**

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

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K 000	INITIAL COMMENTS 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 39 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 met.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
October 8, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5612012

Dear Ms. Doughty:

The above facility was surveyed on September 22, 2014 through September 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

Please 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	23242	A. BUILDING: _____ B. WING _____	09/25/2014

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 22, 23, 24, 25 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Census: 38	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		

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21390	Continued From page 2 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene was followed and reusable equipment was properly cleaned during a dressing change for 1 of 1 resident (R24). Findings included: On 9/24/14, at 9:22 a.m. registered nurse (RN)-B was observed to enter R24's room and wash her hands. LPN-B entered R24's room, carrying dressing change supplies in a pink basin, and washed her hands. R24 was observed seated in a wheelchair with her right foot bare and a stocking to her left foot. R24 stated she had removed the dressing from her right foot prior to their entrance. RN-B removed R24's left stocking and donned gloves. LPN-B placed a disposable absorbent pad with a waterproof backing on the floor, under R24's feet, and donned gloves. RN-B measured the wound to the underside of R24's right foot at the metatarsal head of the great toe and stated it was 0.5 cm x 0.8 cm. RN-B held R24's foot aloft while LPN-B cleansed the wound using a wet wash cloth and baby	21390		

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21390	Continued From page 3	21390		

shampoo. LPN-B dried the wound with a towel and removed and discarded her gloves into the bedside garbage can. No hand hygiene was observed.
LPN-B then retrieved a scissors from her pocket and donned clean gloves. LPN-B opened an 8 x 8 inch Mepilex (antimicrobial foam) dressing and cut off a portion of the dressing to cover the size of the wound, using the scissors without cleansing them prior to use. LPN-B returned the scissors to her pocket and applied the Mepilex dressing to the wound.
LPN-B then removed her gloves, opened a gauze bandage roll and wrapped the gauze around R24's right foot. LPN-B retrieved the scissors from her pocket, cut the gauze bandage, and returned the scissors to her pocket, without cleansing prior to use. LPN-B opened a package of Coban (self-adherent elastic wrap that functions like a tape) and wrapped it around R24's right foot to secure the gauze bandage. LPN-B retrieved the scissors from her pocket, cut the Coban and returned the scissors to her pocket.
LPN-B returned the Mepilex, gauze and Coban dressings to the basin. RN-B removed and discarded her gloves into the bedside garbage can. RN-B washed her hands. LPN-B discarded the absorbent pad into the bedside garbage and bagged the soiled washcloths. RN-B applied alcohol based hand sanitizer and left the room.

LPN-B washed her hands and left the room with the soiled, bagged washcloths, basin with dressing supplies, and baby shampoo. She placed the soiled linen in the soiled utility room and returned to the med cart with the basin and the baby shampoo. LPN-B then donned gloves and wiped off the baby shampoo with an alcohol wipe, returned it to the basin, discarded her

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21390	Continued From page 4 gloves into the medication cart trash can and put the basin away in the medication room. On 09/24/2014, at 9:43 a.m. LPN-B confirmed did not wash her hands or use hand sanitizer after cleansing the wound and before applying new gloves and confirmed she should have done so. LPN-B also confirmed that she put the used scissors back in her pocket and did not clean them after use and had not cleaned them prior to use. LPN-B stated she usually cleaned her scissors with alcohol wipes after she had used them. On 09/25/2014, at 5:18 p.m. director of nursing (DON) confirmed hand hygiene should have been completed after cleansing the wound and prior to applying clean gloves. DON also confirmed the scissor should have been cleaned with a sani-wipe prior to use. The Dressings, Dry/Clean policy dated June 2005, directed staff to wash and dry hands thoroughly prior to opening clean dressing packages and donning clean gloves. The Wound Care policy dated April 2009 directed staff to wipe reusable supplies such as scissor blades with alcohol prior to use. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff to ensure proper hand hygiene and equipment cleaning was maintained during resident cares. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21390		

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21390	Continued From page 5 (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide tuberculosis (TB) symptom screening for 1 of 1 newly hired registered nurse (RN)-C; 2 of 2 newly hired nursing assistants (NA)-G, NA-H; 1 of 1 newly hired housekeepers (HSK)-A; 1 of 1 newly hired dietary staff (D)-B and for 2 of 5 residents (R72, R76) reviewed. Tuberculin skin testing was not provided for 2 of 5 residents (R19, R76) upon admisisong. In addition, there was no policy that	21426		

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21426	Continued From page 6 directed initial and on-going training of employees in relation to TB. There was no documented TB training upon hire for 1 of 1 newly hired RN's (RN-C), 1 of 1 newly hired NAs (NA-H), and 1 of 1 newly hired housekeepers (HSK-A). This had the potential to affect all 38 residents who resided in the facility. Findings include: RN-C was hired 6/5/14. There was no documentation TB symptom screening or TB education upon hire. NA-G was hired 8/12/14. There was no documentation TB symptom screening had been done. NA-H was hired 5/27/14. There was no documentation TB symptom screening had been done. There was no documentation of initial TB training upon hire. HSK-A was hired 8/25/14. There was no documentation TB symptom screening had been done. There was no documentation of initial TB training upon hire. D-B was hired 7/1/14. There was no documentation TB symptom screening had been done. R72 was admitted 5/13/14. There was no documentation TB symptom screening had been done. R76 was admitted 7/2/14. There was no documentation TB symptom screening had been done. There was no documentation 1st or 2nd step tuberculin skin testing (TST) or	21426		

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21426	Continued From page 7 Interferon-Gamma Release Assays (IGRA) (blood test to diagnose Mycobacterium tuberculosis) had been administered or chest x-ray performed. R19 was admitted 6/19/14. There was no documentation 1st or 2nd step TST or IGRA had been administered or chest x-ray performed. On 9/24/14, at 1:40 p.m. director of nursing (DON) confirmed the facility had not been doing symptom screening for newly hired employees and therefore was not completed for RN-C, NA-G, NA-H, HSK-A and D-B. On 9/25/14, at 7:51 a.m. DON confirmed there was no documentation of TB symptom screening for R72 and R76 and no documentation of 1st or 2nd step TST, IGRA or chest x-ray for R19 and R76. On 9/25/14, at 5:16 p.m. DON confirmed the new employee orientation checklist indicating completion of TB training was blank and there was no documentation TB training had been received for RN-C, NA-H and HSK-A. DON confirmed the facility did not have a policy for the provision of initial and ongoing TB training for employees. The Tuberculosis Control for Healthcare Workers policy dated September 2014 indicated baseline TB screening would be performed on all new staff and volunteers and included assessing for current symptoms of active TB disease. The Screening Residents for Tuberculosis policy dated April 2007 indicated the facility would screen all residents for exposure to or symptoms of TB infection and disease. The policy also indicated any resident without documented negative TST, blood assay for Mycobacterium tuberculosis	21426		

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21426	Continued From page 8 (BAMT) or chest x-rays within the previous 12 months would receive a baseline (two-step) TST or (one step) BAMT upon admission. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents and staff have appropriate documentation of mantoux results and screening in lieu of tuberculin serum availability according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for	21540		

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21540	Continued From page 9 review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide provide side effect monitoring for anticoagulant medications for 2 of 5 residents (R10, R24) reviewed for unnecessary medications. Findings include: R10 was observed on 9/24/14 at 9:19 a.m., with a purple bruise on the right forearm. R10's Anticoagulation Clinic Communication form dated 9/23/14, included orders to hold the Warfarin (Coumadin, a medication used to thin the blood) on 9/23/14 and 9/24/14 and give 0.5 milligrams (mg) on 9/25/14. R10 had bruising on the back of the calves that appeared after three days (9/13/14-9/15/14) of Lovenox (injectable anticoagulant medication). R10 was admitted on 7/5/11, and the Admission Record updated for 9/25/14, indicated diagnoses that included, deep vein thrombosis (blood clot), dysarthia (a motor speech disorder), depression and dementia without behavioral disturbance. The quarterly Minimum Data Set dated 8/29/14, indicated R10 was cognitively intact and was receiving an anticoagulant (blood thinner) medication.	21540		

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21540	Continued From page 10 Monitoring for potential adverse effects of anticoagulant therapy were not addressed on R10's care plan with a print date of 3/25/14, or on the electronic medication record (EMR) and treatment record (TAR) dated 8/1/14, through 9/23/14. On 9/25/14, at 3:30 p.m. the director of nursing (DON) verified the Coumadin monitoring was not on the care plan as it should have been. R24 was receiving Coumadin without monitoring for potential adverse effects. R24's Admission Record printed 9/25/14, indicated diagnoses that included atrial fibrillation and long term use of anticoagulants. The admission Minimum Data Set (MDS) dated 7/24/14, indicated R24 was cognitively intact and was receiving anticoagulant medication. The Consolidated Orders (Chart) Report dated 9/23/14, identified R24 received Coumadin 1.5 milligrams (mg) by mouth daily. Monitoring for potential adverse effects of Coumadin was not addressed on the care plan dated 7/28/14, or on MAR/TAR dated 8/1/14 through 9/23/14. On 9/24/14, at 9:22 a.m. R24 was observed seated in her wheelchair, in her room, wearing a short sleeved night gown. Her demeanor was calm and her skin was observed to be intact without bruising noted to her arms, hands, or legs. On 9/25/14, at 3:16:14 p.m. registered nurse (RN)-B confirmed side effect monitoring for Coumadin was not addressed in the care plan.	21540		

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21540	Continued From page 11 On 9/25/14, at 5:08 p.m. the DON stated the only monitoring for Coumadin use was INR (international normalized ratio) testing (laboratory measurement used to determine the effects of oral anticoagulants on blood clotting). DON confirmed nothing was formally documented on the care plan directing staff to monitor for potential side effects of Coumadin use. The Anticoagulation-Clinical Protocol dated April 2007 indicated the staff would monitor for possible complications in individuals who were being anticoagulated. The protocol identified if individuals on anticoagulation therapy showed signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse would discuss the situation with the physician before the next scheduled dose of anticoagulant was given. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to monitoring and use of medications. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance. Time period for correction: Twenty one (21) days.	21540		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the	21840		

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21840	Continued From page 12 likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the risks and benefits of refusing range of motion (ROM) rehabilitation services were addressed and documented for 1 of 3 resident (R13) reviewed for ROM services. Findings include: R13's Admission Record dated 4/23/14, indicated R13 had diagnoses that included paralysis agitans and generalized osteoarthrosis. R13's quarterly Minimum Data Set (MDS) dated 8/2/14, indicated R13 was cognitively intact and had functional impairment of both upper extremities. The MDS indicated R13 was not on a restorative nursing program for ROM or splint/brace assistance. R13's Care Plan dated 4/30/14, indicated R13 refused to participate in PT/OT [physical therapy/occupational therapy] evaluations. The Occupational Therapy Discharge note dated 7/3/14, indicated R13 was referred to restorative nursing for ROM of upper extremities and neck.	21840		

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21840	Continued From page 13	21840		

The note also indicated R13 did not want to use a splint/orthosis and noted minimal change with upper extremity ROM.

The Cornerstone Villa Restorative Care Plan sheets dated July 2014, August 2014 and September 2014 directed staff to walk R13 as much as tolerated or provide ROM to lower extremities. The Care Plan sheets did not direct staff to provide upper extremity or neck ROM for R13.

On 9/23/14, at 3:56 p.m. R13 was observed resting in bed, awake and alert. His left hand was observed to be contracted and without a splint.

On 09/24/2014, at 7:29 a.m. R13 was observed up and dressed seated in a wheelchair at a table in the dining room. No splint was observed to R13's left hand contracture.

On 09/23/2014, at 3:56 p.m. R13 stated he used to have therapy to his left hand but stated they stopped that because, "It wasn't any use". R13 also stated he used to wear a splint but did not wear one any longer.

On 09/24/2014, at 2:30 p.m. nursing assistant (NA)-E stated R13 ambulated everyday around the loop or to supper. She stated R13's left hand and upper extremity were very stiff and they did not do anything with this. NA-E further stated therapy staff put the restorative sheets together for the restorative aides to follow.

On 09/24/2014, at 2:37 p.m. Certified Occupational Therapy Aid (COTA) confirmed the therapy department put together the restorative sheets. COTA also confirmed the OT discharge note indicated a restorative nursing program

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21840	Continued From page 14 including ROM of R13's upper extremities and neck was recommended. COTA stated she screened R13 for OT and he had no decline in his upper extremity ROM. Rehabilitation Screen forms dated 7/30/14, 8/21/14, and 9/23/14 were reviewed and indicated no decline in ROM. COTA stated R13 had refused any services, braces or washcloths in his hands and she was focused on R13 being able to use a walker as ambulation was important to R13. On 9/25/14, at 8:05 a.m. COTA indicated the restorative recommendations made by the Occupational Therapist were never implemented due to R13's refusal to participate. COTA confirmed there was no documentation in the record of education regarding risks versus benefits related to the ROM to the upper extremities. The Risk/Benefit Policy dated August 2013 indicated residents who refused to participate in goals outlined in the resident's plan of care would be advised by nursing and/or therapy staff of the risks associated with their refusal and advised of the benefits of following the plan of care. The policy also indicated if the resident continued to refuse participation in the plan, it would be documented in the resident's medical record. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the resident's refusal of care. The DON, or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident's plan of care. The DON, or designee(s) could monitor to assure each resident's receives proper care.	21840		

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21840	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21840		