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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IICS

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 **06/20/2016** (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

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 07/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/16/2004** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
07/12/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245612

August 8, 2016

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 June 17, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.
Sincerely,
Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
F ax: (651) 215-9697.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 15, 2016

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

RE: Project Number S5612014

Dear Ms. Doughty:

On May 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 12, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 12, 2016, effective June 17, 2016 and therefore remedies outlined in our letter to you dated May 25, 2016, 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245612 Y1	A. Building B. Wing Y2	6/20/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	06/17/2016	LSC	06/17/2016	LSC	06/17/2016
ID Prefix F0315	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	06/17/2016	LSC	06/17/2016	LSC	06/17/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/17/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TA/mm	07/15/2016	29433	06/20/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/12/2016

[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245612	A. Building 01 - MAIN BUILDING 1 B. Wing	6/27/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/06/2016	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	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	07/15/2016	27200	06/27/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/10/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IICS

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: **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 **05/12/2016** (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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR SWS — 06/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 07/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/16/2004** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24 5612

On May 12, 2016 a standard survey was completed at this facility. The most serious deficiencies were cited at a S/S level of F, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed.

LSC deficiency K25 was cited at the time of the standard survey. However, on May 17, 2016, a Fire Safety Evaluation System (FSES) was conducted and determined LSC deficiency cited at K25 was in compliance as a result of the FSES. Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction, FSES Notice dated May 26, 2016, FSES Worksheets and related documents for the results of the standard and FSES surveys. Health Post Certificatoin Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 25, 2016

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

RE: Project Number S5612014

Dear Ms. Doughty:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (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 June 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 21, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 August 12, 2016 (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 November 12, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	05/12/2016

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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frequency of bathing preferences were honored for 2 of 3 residents (R6, R29) reviewed for choices. Findings include: R6's Admission Record identified diagnoses that included muscle weakness and congestive heart failure. R6's quarterly Minimum Data Set (MDS) dated 4/10/16, indicated R6 was cognitively	F 242	Cornerstone Villa strives to ensure that all resident rights, including the right to choose, are honored and protected. CORRECTIVE ACTION: Residents R6 and R29 were interviewed on 5/13/2016 by the Social Services Director and asked about their bathing preferences as well as other preferences. Bathing preferences included number of	6/17/16

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

Electronically Signed | 06/10/2016

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.

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	245612	A. BUILDING _____ B. WING _____	05/12/2016

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F 242	Continued From page 1 intact, was totally dependent upon staff for bathing, and needed extensive assistance with activities of daily living (ADL's) including transferring. R6's care plan dated 2/4/16, indicated R6 needed an assist of one person for bathing. R6's undated bath sheet indicated R6's shower day was Monday a.m., and she had received weekly showers since 1/4/16, except when out of the facility for hospitalizations. On 5/9/16, at 5:22 p.m. R6 stated she gets one shower a week. R6 stated she would like more than one shower but "I don't get it." On 5/12/16, at 9:14 a.m. R6 again stated she gets one shower a week and she would like to have at least two a week. R6 stated they just tell you and "you take the shower when it comes." R29's Admission Record identified diagnoses that included right tibia fracture, muscle weakness and pain. R29's admission MDS dated 2/8/16, indicated R29 was cognitively intact, required physical assistance with bathing, and needed extensive assistance with most ADL's. R29's care plan dated 2/11/16, indicated R29 required extensive assistance with bathing. R29's undated bath sheet indicated R29's bath day was Wednesday morning, and R29 had received weekly showers from 2/3/16, through 5/4/16. On 5/11/16, at 8:11 a.m. R29 stated she was told she can only have a bath or shower once a week. When asked if she would like more than one, R29 stated "of course, who wouldn't?" During an observation on 5/11/16, at 8:16 a.m.	F 242	times per week, time of day, and what day of week. A resident choice document was completed and placed in the resident social services file after the resident plan of care and daily assignment/bathing sheets were updated. These preferences will be reviewed and updated at a minimum of quarterly during the resident quarterly review. Resident R6 chose to be bathed twice weekly; Resident R29 chose to be bathed twice weekly. These choices were communicated to nursing staff and the bathing sheets/schedules were updated for these preferences. CORRECTIVE ACTION AS IS PERTAINS TO OTHER RESIDENTS: All residents (where appropriate resident representatives) were surveyed for bathing preferences (as well as other preferences) on or before 5/27/2016. All were asked about bathing preferences as they relate to number of times per week, time of day, and day of week. A resident preferences document was completed and placed in the resident social service file, which will be reviewed and updated at a minimum of quarterly during their quarterly review. The staff bathing/assignment daily sheets were updated with the new preferences as was the resident plan of care. CHANGE TO PREVENT RECURRENCE: Resident Preference Policy and Procedure was reviewed and updated on 5/13/2016. Staff were inserviced on 5/19/2016 on resident rights of choice which included their right to choose	

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F 242	Continued From page 2 R29 was observed requesting her bath from nursing assistant (NA)-A. At 8:19, NA-A went to fill the tub, and R29 reminded NA-A where her room was, concerned that NA-A wouldn't find her for her bath. R29 then returned to sit on the side of her bed. In an interview on 5/12/16, at 8:57 a.m., the Resident Services Director (RSD) stated one bath a week is standard unless a resident has a different preference. The RSD stated either she or the nursing staff admitting a resident will ask if a resident wants a shower or a bath. The RSD also stated she doesn't routinely offer more than one shower or bath a week. The RSD indicated care conferences occurred quarterly and provided a Care Conference Check List that indicated social services "preferences" were reviewed. The RSD also provided a Resident Preferences worksheet for use on admission and quarterly, but stated she has "fallen away" from using it, and thus does not routinely ask how many times a week a resident would like a bath or shower. The RSD stated she did not have one of these forms from R29's admission. In an interview on 5/12/16, at 9:43 a.m. licensed practical nurse (LPN)-A stated residents are scheduled for one bath a week. LPN-A stated the facility doesn't offer more than one bath or shower a week, but if a resident or their family asks, they will accommodate more baths or showers. In an interview on 5/12/16, at 9:55 a.m. registered nurse (RN)-A stated she is often involved in resident's admission process. RN-A stated the facility schedules residents bath or shower once a week, but if someone voices they want more,	F 242	bathing times per week, time of day, and day(s) of the week. Upon admission all new residents will be surveyed on their bathing preferences as well as other preferences. A Resident Preferences Document will be completed and placed in the resident social service file. Bathing schedules/sheets will be updated with this information as well as the daily assignment sheets and resident plan of care. Each resident, during their quarterly review, will be asked to update their preferences and a Resident Preferences Document will be completed and placed in the resident file and all daily assignment sheets/schedules and the resident plan of care will be updated to include any changes. Monitoring: The Administrator will audit all new resident admissions and three (where available) resident quarterly reviews weekly to ensure that Resident Preference Documents were completed, placed in the resident social service file, documented in the resident plan of care, and documented on the daily assignment sheets/schedules. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	

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F 242	Continued From page 3 they will honor the requests. RN-A stated that she doesn't typically ask if someone wants more than one. In an interview on 5/12/16, at 10:41 a.m. the director of nursing (DON) stated bathing preferences is something that is asked when a resident first comes through the door. The DON stated one bath or shower a week is standard, but a resident or family can ask for more. The DON did not think there was a document that indicated the facility told residents they could request more than one bath or shower a week. The facility policy and procedure Resident Right of Choice dated 9/13, directed upon admission and at least quarterly thereafter resident will be asked about their preferences including frequency of bathing. These preferences will be documented on Resident Preference Forms and the information will be communicated to the respective departments.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting services were provided as directed by the care plan for 1 of 3 residents (R28) reviewed for incontinence.	F 282	Cornerstone Villa strives to ensure that all needed services are provided to residents as directed by the resident plan of care. CORRECTIVE ACTION:	6/17/16

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F 282	Continued From page 4 Findings include: R28's Admission Record printed 5/12/16, indicated R28's diagnoses included vascular dementia, Parkinson's Disease, and hemiplegia and hemiparesis following a cerebrovascular disease (weakness/paralysis on one side of the body following a stroke). R28's quarterly Minimum Data Set (MDS) indicated R28 had a moderate impairment of cognitive skills for daily decision-making, sometimes understood communication by others and was understood by others, and required total staff assistance for transfers and toilet use. The MDS further indicated R28 did not reject care during the assessment period for the MDS. R28's care plan dated 5/9/16, directed staff to place R28 on the toilet when voices the urge. R28's undated care guide sheet, directed staff to check R28 every 2 hours and place on the toilet when voices the urge. On 5/11/16, at 9:24 a.m. two staff entered R28's room and stated they needed to reposition R28. Nursing assistant (NA)-A and NA-D transferred R28 with a hoyer lift to the bed. R28 stated she had to have a "pee" and stated she wanted to go to the toilet. NA-D checked the brief and told R28 she was dry. During an interview immediately following cares, NA-D stated R28 has used the toilet, but usually does not go when they do put her on the toilet. NA-B stated it was uncomfortable for her to sit on the toilet. NA-A stated R28's care plan stated to check and change R28 every 2 hours. NA-A stated she may need to have a BM.	F 282	The plan of care and CNA assignment sheet for resident R28 were reviewed to ensure the information was up to date and accurate. CNAs were inserviced via staff report immediately on R28's plan of care as it pertains to toileting: needs to be placed on the toilet when communicating her need/desire as well as checked/changed every two hours when she does not communicate her need/desire. CORRECTIVE ACTION AS IT PERTAINS TOOTHER RESIDENTS: The Using the Care Plan Policy and Procedure was reviewed, updated, and communicated to staff. Staff were inserviced on 5/19/2016 regarding the need to follow resident care plans as well as following the resident daily care/assignment sheets and making sure that these sheets are reviewed at the beginning of each shift to identify any changes in care. CHANGE TO PREVENT RECURRENCE: Staff were inserviced on 5/19/2016 regarding the need to follow both the resident plan of care as well as the resident daily assignment/care sheets. Staff were reminded to review these sheets each day at the beginning of their shift to ensure that they are aware of each residents' most current needs. Any new or changed information will be highlighted for one week after the change occurred in order to draw attention to the new information.	

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F 282	Continued From page 5 On 5/12/16, at 9:22 a.m. NA-G stated sometimes R28 will ask to use the toilet and they put her on the toilet when she asks. On 5/12/16, at 10:17 a.m. the director of nursing (DON), verified staff should have toileted R28 when she asked. The DON further verified the care plan and the care guide sheets directed R28 should be put on the toilet when she asks, and the care plan was not followed. The facility policy and procedure Using the Care Plan revised 8/06, directed nursing assistants to report any changes in the resident's care plan goals and objectives that have not been met or expected outcomes that have not been achieved. The policy indicated the care plan would be used in developing the resident's daily care routines.	F 282	Monitoring: The Director of Nursing or designee will audit three (3) residents per shift to ensure that staff are following the resident plan of care. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pressure-related skin conditions were identified and monitored for 1 of 3 residents (R52) reviewed for skin conditions.	F 309	Cornerstone Villa strives to ensure that each resident receives the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.	6/17/16

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F 309	Continued From page 6 Findings include: On 5/9/16, at 4:01 p.m. R52 was observed to have bruises on her posterior lower left arm, between the wrist and elbow. On 5/11/16, at 6:43 a.m. R52 was observed to have two bruises on the left forearm and a bruise on the outer right elbow and mid forearm. R52's Admission Record printed 5/12/16, indicated R52's diagnoses included anemia, dementia with behavioral disturbance, chronic kidney disease, and a history of falling. R52's quarterly Minimum Data Set (MDS) dated 3/12/16, indicated R52 had a severe cognitive impairment, required extensive assist of two staff for bed mobility, and extensive assist of one staff for transfers. The MDS also indicated R52 required extensive assistance of 1 staff for locomotion in the wheelchair, personal hygiene, and dressing, and had a balance impairment which required the assistance of others to stabilize her. The MDS further indicated R52 had one fall without injury since the previous MDS, had no behaviors during the assessment period for the MDS, and had no skin concerns. R52's physician orders dated 4/13/16, indicated R52 received aspirin 81 milligrams (mg) daily, which was started on 6/26/15. R52's care plan dated 7/16/15, indicated R52's skin was to be monitored daily with cares and on bath days. R52's care plan lacked documentation of R52's potential for bruising. R52's progress notes lack documentation	F 309	Corrective Action: Resident R52 information was recorded on a resident incident report as well on the E-TAR. Nursing staff are required, per the newly developed Non-pressure Related Skin Condition Policy and Procedure to identify, document, and monitor all non-pressure related skin conditions. Monitoring skin condition will occur shiftly (minimum of AM and PM) to identify any negative changes. Corrective Action As It Pertains To Other Residents: All residents were assessed for non-pressure related skin conditions. An incident report was completed for each resident with an identified skin condition and this condition was documented on the E-TAR to ensure that nursing staff were monitoring the condition shiftly (minimum of AM and PM) for any negative changes. Change to Prevent Recurrence: A Non-Pressure Related Skin Condition Policy and Procedure was developed and communicated at the 5/19/2016 all staff inservice which included identification, reporting, documenting, and monitoring of the non-pressure related skin condition. Residents identified/reported to have a non-pressure skin condition will have an incident report completed and this condition will be documented on the E-TAR to ensure that the condition is monitored by nursing staff shiftly (minimum of AM and PM) for any negative changes. Monitoring will continue until the	

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F 309	Continued From page 7 regarding bruising on R52's arms. R52's bruises were not identified or monitored on the 5/16, medication administration record (MAR) and treatment administration record (TAR). On 5/11/16 at 6:41 a.m. R52 was observed propelling her wheelchair around in the hallway when she became stuck in another resident's room doorway, and at 6:43 a.m. R52 maneuvered the wheelchair out of the doorway and back into the hallway. On 5/11/16, at 7:08 a.m. R52 was observed propelling her wheelchair around in circles in the dining area, by the nurse's station. On 5/11/16, at 7:45 a.m. R52 was observed propelling her wheelchair in the hallway near her room and was ramming the wheelchair back into the walls and doorframes. On 5/12/16, at 10:03 a.m. the director of nursing (DON) stated bruises were to be monitored on the MAR or the TAR. The DON stated when bruises are found, incident reports are completed and it the bruising is investigated. The DON verified the potential for bruising would be noted on the care plan. On 5/12/16, at 10:35 a.m. nursing assistant (NA)-D stated R52's bruises were probably from bumping into walls, door frames, and other things. NA-D stated the NAs report bruises to the nurses when the bruises are found. NA-D stated she assumed R52's bruises were reported. NA-G was present during the interview and verified the same information.	F 309	condition is resolved. The incident report now has a line for documenting that the condition has been added to the E-TAR as these incident reports are reviewed daily (M-F) by the ID Team. Monitoring: The Director of Nursing will audit all reports of non-pressure related skin conditions to ensure that the condition has been documented on the E-TAR and that nursing staff is monitoring the condition shiftly (minimum of Am and PM).	

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F 309	Continued From page 8 On 5/12/16, at 10:50 a.m. registered nurse (RN)-A measured R52's bruises on her arms. RN-A stated bruises are usually monitored on the MAR. RN-A verified R52's potential for bruising was not on R52's care plan, and stated R52 bruises easily and bumps her arms on the walls, and other things. R52 denied pain of the bruised areas and stated she was not sure what happened when she was asked by RN-A. Measurements of R52's bruises were: Left inner forearm: 1 x 2.5 centimeters (cm) Left lower outer forearm: 1 x 0.5 cm Left upper outer: 1.2 x 2.2 cm Right elbow: #1 1.5 x 0.5 cm; #2 1.5 x 1.5 cm Right lower forearm: 2 x 1.2 cm A policy and procedure for non-pressure-related skin conditions was requested and was not provided.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting	F 315	Cornerstone Villa strives to ensure that all resident requests for services are	6/17/16

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F 315	Continued From page 9 services were provided upon resident request for 1 of 3 residents (R28) reviewed for incontinence. Findings include: R28's Admission Record printed 5/12/16, indicated R28's diagnoses included vascular dementia, Parkinson's Disease, and hemiplegia and hemiparesis following a cerebrovascular disease (weakness/paralysis on one side of the body following a stroke). R28's quarterly Minimum Data Set (MDS) assessment indicated R28 had a moderate impairment of cognitive skills for daily decision-making, sometimes understood communication by others and was understood by others, and required total staff assistance for transfers and toilet use. The MDS further indicated R28 did not reject care during the assessment period for the MDS. R28's care plan dated 5/9/16, directed staff to place R28 on the toilet when voices the urge. R28's undated care guide sheet, directed staff to check R28 every 2 hours and place on the toilet when voices the urge. R28's Bowel Assessment dated 4/2/16, indicated R28 was able to feel the urge for a bowel movement (BM) and staff were to put R28 on the toilet when she verbalized the need to go, though sometimes had already been incontinent of bowel. R28's Bladder Assessment dated 4/2/16, indicated R28 does not void when placed on the toilet, but will have a BM when placed on the toilet, when she verbalizes the need, at times.	F 315	provided in a timely, dignified manner. Corrective Action: Staff were inserviced on the need to toilet R28 when resident "voices urge" as stated in the resident plan of care and on the resident daily care sheet. This was completed on 5/12/2016. Corrective Action as it Pertains to Other Residents: The Policy and Procedure for Using the Care Plan was Updated, Reviewed and communicated to staff on 5/19/2016. Staff were inserviced on the need to review the resident care sheets during all rounds in order to identify any changes that may have occurred and to ensure that staff are aware of the residents plan or care. Change to Prevent Recurrence: The Policy and Procedure for Using the Care Plan was Updated and Reviewed with Staff on 5/19/2016. Staff were inserviced on the need to review the resident care sheets during all rounds in order to identify any changes that may have occurred and to ensure that staff are aware of the services documented in the residents plan of care. Monitoring: The Director of Nursing or designee will audit three (3) residents per shift to ensure that staff are performing toileting services as stated in the resident plan of care as well as on the resident daily assignment sheets. These audits will	

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F 315	Continued From page 10 The Bladder Assessment indicated staff were to put R28 on the toilet when she verbalized the need to use it. On 5/11/16, at 9:24 a.m. two staff entered R28's room and stated they needed to reposition R28. Nursing assistant (NA)-A and NA-D transferred R28 with a hoyer lift to the bed. R28 stated she had to have a "pee" and stated she wanted to go to the toilet. NA-D checked the brief and told R28 she was dry. NA-A and NA-D pulled R28's slacks up and covered her with a blanket. During an interview immediately following cares, NA-D stated R28 has used the toilet, but usually does not go when they do put her on the toilet. NA-B stated it was uncomfortable for her to sit on the toilet. NA-A stated R28's care plan stated to check and change R28 every 2 hours. NA-A stated she may need to have a BM. The BM Sheet dated 5/11/16, indicated R28 did have a BM on that date. The NA care guide sheet dated 5/11/16, day shift indicated R28 had a BM during that shift. On 5/12/16, at 9:22 a.m. NA-G stated sometimes R28 will ask to use the toilet and they put her on the toilet when she asks. On 5/12/16, at 10:17 a.m. the director of nursing (DON) verified staff should have toileted R28 when she asked. The DON further verified the care plan and the care guide sheets directed R28 should be put on the toilet when she asks, and the care plan was not followed. The facility policy and procedure for Using the Care Plan revised 8/06, directed nursing assistants to report any changes in the resident's	F 315	continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	

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	245612	A. BUILDING _____ B. WING _____	05/12/2016

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F 315	Continued From page 11 care plan goals and objectives that have not been met or expected outcomes that have not been achieved. The policy indicated the care plan would be used in developing the resident's daily care routines.	F 315		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		6/17/16

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F 431	Continued From page 12 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to ensure a policy and system had been implemented to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion. This had the potential to affect all 41 residents residing in the facility. Findings include: R28's Admission Record identified diagnoses including vascular dementia with behavioral disturbance, delusional disorders, bipolar disorders, anxiety disorders, hemiplegia and hemiparesis following cerebrovascular disease and polyarthritis. R28's quarterly Minimum Data Set (MDS) dated 4/2/16, indicated R28 had memory problems. On 5/11/16, at 1:57 p.m. the Tamarack unit medication cart was observed to have an oxycodone (a narcotic pain medication) 5 milligram (mg) medication unit dose card assigned to R28 with two tablets contained within taped over broken seal compartments. The tablets contained within the broken seal compartments lacked identifying information, and there were no signatures identifying the staff person(s) who had taped over the broken seals. On 5/11/16, at 2:00 p.m. registered nurse (RN)-B was interviewed and stated he was not aware of any instructions or policy regarding the disposition	F 431	Cornerstone Villa strives to ensure that all medications are stored and destroyed in a way that has the least potential to affect the residents. Corrective Action: On 5/11/2016 the Director of Nursing and a staff Registered Nurse documented and destroyed all expired and discontinued medications. Corrective Action as it Pertains to Other Residents: A Policy and Procedure for Medication Destruction was developed and reviewed with all licensed staff on 5/19/2016. The P&P states that all expired and/or discontinued medications will be destroyed within 72 hours of expiration or discontinuation. This will be completed by Nursing Staff per the medication destruction P&P. Change to Prevent Recurrence: The Policy and Procedure for Medication Destruction will be provided to the facility Pharmacy Consultant. The medication destruction process will be reviewed by the pharmacy consultant each month as a part of the facility monthly pharmacy review to ensure that the P&P is being followed.	

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F 431	Continued From page 13 of narcotics contained within compromised unit dose packaging and said he would be unable to verify that the tablets within the compromised unit dose packaging were the medication as originally packaged. On 5/11/16, at 2:10 p.m. the Tamarack wing medication storage area was observed. The medication storage area had multiple containers of controlled substance medications, among which included multidose bottles of liquid morphine, liquid methadone, non-unit dose bottles of oxycodone and fentanyl patches. The list of controlled substances included the following in unit dose cards and bottles: Oxycontin 40 milligrams (mg) x 31 pills Dilaudid 2 mg (an opioid pain reliever) x 62 pills Norco (hydrocodone 10mg/acetaminophen 325 mg) x 25 pills Dilaudid 1 mg x 30 pills Oxycodone/acetaminophen 10/325 mg x 30 pills Ultram (narcotic type pain reliever) 50 mg x 213 pills Norco 5/325 mg x 70 pills Adderall (an amphetamine with addictive properties) 20 mg x 2 pills Lortab (hydrocodone/acetaminophen) 7.5/325 mg 473 milliliters (ml) x three bottles Amphetamine Salts 20 mg x 30 pills Oxycodone 5 mg x 190 pills Hydrocodone 7.5 mg x 20 pills Hydromorphone 2 mg x 39 pills Vyvanse (an amphetamine with addictive properties) 30 mg x 14 pills Temazepam (benzodiazepine used to treat insomnia) 7.5 mg x 28 pills Codeine/acetaminophen 30/300 mg x 28 pills	F 431	Monitoring: The Director of Nursing or Designee will audit three (3) residents weekly who have had medication discontinuations and/or expirations to ensure that the medications were destroyed per the Medication Destruction Policy and Procedure. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	

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F 431	Continued From page 14 Tramadol 50 mg x 110 pills Hydrocodone/acetaminophen 7.5/325 mg x 47 pills Fentanyl (opioid pain reliever) patch 50 mcg/hour x 7 patches Methadone 10mg/ml (an opioid used to treat pain and ease drug withdrawal) Methadone 10mg/ml x 5 ml Morphine Sulfate 20 mg/ml x 50 ml On 5/11/16, at 2:15 p.m. RN-C and RN-B were interviewed. RN-C stated there was no policy in place directing the disposition of controlled medications. RN-B said these controlled substances may be stored for several months in the medication storage area until licensed nursing staff had time to destroy the medications together. RN-B confirmed multiple licensed nursing staff would have access to the medication storage area during the storage time awaiting medication destruction and the integrity of some of the opened medication containers could not be assured. On 5/12/16, at 10:46 a.m. the director of nursing (DON) was interviewed and stated the controlled substances contained within medication storage area were stored there as early as 2/16. The DON stated the facility planned to institute a policy of controlled substance destruction upon resident discharge from the facility. On 5/12/16, at 11:03 a.m. the consultant pharmacist was interviewed and stated he was no longer involved in the destruction of controlled medications from the facility. The consultant pharmacist said he was aware the facility had previously used a good process for the timely destruction of controlled medications, but said the	F 431		

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F 431	Continued From page 15 procedure could get messy and lead to potential diversion of the medications when controlled medications are stored for long periods of time. The facility's Controlled Substances policy revised 4/07, lacked direction on the handling of narcotics contained within unit dose containers with compromised seals. The facilty Discarding and Destroying Medications policy dated 4/07, lacked direction on timely destruction of controlled drugs.	F 431		
F 441 SS=F	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 - (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	F 441		6/17/16

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F 441	Continued From page 16 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 failed to consistently implement contact precautions for 1 of 1 residents (R6) diagnosed with clostridium-difficile (C-diff) infection. These practices had the potential to affect all 41 residents in the facility. Findings include: The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant.	F 441	Cornerstone Villa strives to ensure that infectious contact precautions practices are used by staff and residents. Corrective Action: On 5/12/2016 Director of Nursing educated staff and provided written material regarding contact precautions to be used when providing services for resident R6. Corrective Action As It Pertains To Other Residents: On 5/12/2016 Director of Nursing and designee educated direct care staff on the infection control policies and procedures for contact precautions, CDC guidelines, and proper hand washing quidelines for ensuring the implementation of contact precautions for one resident located on Tamarack unit. All staff were inserviced on 5/19/2016 on need to follow the proper infection control procedures for contact precautions when providing services to	

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F 441	Continued From page 17 R6's Consolidated Orders Report, dated 5/12/16, indicated diagnoses including muscle weakness, a history of falling, congestive heart failure, atrial fibrillation, hypertension, glaucoma, and pneumonia. On 4/27/16, the resident tested positive for C-diff. R6's quarterly Minimum Data Set (MDS) dated 4/10/16, indicated R6 was cognitively intact, but needed extensive assistance with activities of daily living (ADL's) including transferring, toileting, dressing and personal hygiene. R6's MDS also indicated R6 was occasionally incontinent of bladder and frequently incontinent of bowel. R6's care plan dated 2/4/16, indicated R6 required an assist of one staff person to use the toilet and to transfer, for dressing and personal hygiene. R6's care plan dated 2/4/16, indicated R6 had Clostridium difficile (C-Diff, a bacterial infection with symptoms from diarrhea to life threatening inflammation of the colon. C-diff is commonly associated with elderly who have been on an antibiotic and are in hospitals or long term care settings. C-diff is passed in feces and spread to food, surfaces and objects when people who are infections don't wash their hands thoroughly. The bacterial persists in a room for weeks or months. If someone touches a surface contaminated with C-diff you may then unknowingly swallow the bacteria. Hand sanitizer is not effective for preventing the spread of C-diff). During an observation on 5/11/16, at 7:36 a.m. nursing assistant (NA)-A was observed to answer R6's call light. NA-A donned gown, gloves and a mask and entered R6's room. NA-A assisted R6	F 441	residents diagnosed with an infectious disease. Staff were informed on where to locate the CDC Guidelines and the facility Policy and Procedure. Changes To Prevent Recurrence: A packet of information will be placed on the unit for staff to review when a resident is diagnosed with an infectious disease requiring the implementation of precautions. Staff will be immediately informed of the need to follow the precautions and will be inserviced by the unit nurse on what precautions have been implemented. Monitoring: The Director of Nursing or Designee will audit each resident 2x shiftly (6x per day) to ensure staff are using the required contact precautions. These audits will continue until the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	

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F 441	Continued From page 18 to her wheelchair, then to the toilet in R6's room. R6 took hold of the handrails by the toilet and assisted by NA-A stood, transferred and sat on the toilet. NA-A stated there was a "little bm" in R6's brief, but she was not incontinent of urine. After R6 urinated in the toilet, NA-A wiped R6's peri-area from front to back. NA-A changed gloves without completing hand hygiene between glove changes, assist R6 to don a clean brief, flushed the toilet, assisted R6 from the toilet to the wheelchair, and then to bed. NA-A did not remind or assist R6 with hand washing. During an observation on 5/11/16, at 8:53 a.m. NA-A entered R6's room with a breakfast try. NA-A did not don gloves, gown or a mask, but set down the breakfast tray, removed the plate covers without touching R6 or any room surfaces. However, NA-A then opened R6's shades and picked up R6's hearing aide with bare hands. With bare hands, NA-A turned the hearing aide on, held it close to her ear to listen for it's function, and handed the hearing aide to R6. NA-A then took a facial tissue from R6's tissue box and picked up R6's other hearing aide, listened for functionality, and handed it to R6. Before leaving R6's room, NA-A used hand sanitizer to clean her hands. At no time during this observation did NA-A don gown, gloves or a mask nor did NA-A complete hand hygiene by using soap and water. Review of R6's CM Sheet for May 2016 indicated she had loose stools on 5/1 (1 medium), 5/2 (one medium), 5/3 (two large, one medium), 5/4 (one large), 5/8 (one small), 5/9 (one medium), 5/10 and 5/11 (one medium).	F 441		

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F 441	Continued From page 19 In an interview on 5/12/16, at 10:51 a.m., the Director of Nursing (DON) stated she expects staff, when caring for a resident with C-diff to don gown, gloves and a mask. The DON stated she expects staff to wash their hands when leaving the room and to cue and assist the resident to wash her hands after using the toilet. The DON stated that R6's C-diff is contained that R6 is cognitively intact, however, R6 does need to be encourage to wash her hands and to perform this task thoroughly after each toilet use. The DON stated she has informed staff that hand sanitizer won't kill C-diff. The DON stated she would expect staff to at minimum use a glove when handling a hearing aide with a resident with C-diff. The facility policy on Infection Control Guidelines for All Nursing Procedures dated 07, directed when there is likely exposure to spores (i.e. C-diff), employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water. The policy also noted alcohol based hand rubs are inactive against spores. No additional polices on the implementation of precautions for residents with C-diff were provided.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	Cornerstone Villa strives to ensure that	6/17/16

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F 465	Continued From page 20 review, the facility failed to ensure a safe and homelike environment was maintained in 7 of 30 resident rooms (rooms 282, 284, 293, 296, 321, 323, 327). Findings include: On 5/12/16, beginning at 8:15 a.m. during an environmental tour, the director of maintenance (DM) verified the following environmental findings: Room 282: the bathroom walls had scuff marks along the wall. The area was the length of the walls, approximately 10 inches wide and approximately 10 inches from the floor. Room 284: a corner wall of the room near the bathroom had an area broken away exposing the sheetrock making the area rough and uncleanable. Room 293: the bathroom door had scratches in the wood. The walls in bathroom along the bottom had scrapes exposing the sheetrock making it an uncleanable surface. In addition, the bathroom and bedroom walls had black scuff marks along the bottom. Room 296: the paint on the bathroom door frame was scraped off at the bottom of the frame. The bathroom door had an area of missing laminate approximately three inches by two inches near the handle exposing rough wood. Room 321: had a large chipped area on the wall next to the bathroom door. The paint on the bathroom door frame was scraped off at the bottom of the frame. There was a large gouge	F 465	the facility is maintained in a safe, clean, and sanitary manner. Corrective Action: Maintenance staff corrected all environmental findings in resident room 282, 284, 293, 296, 321, 323, 327. This work was completed by 5/31/2016. Corrective Action As It Pertains To Other Residents: The Maintenance Supervisor and staff developed a list of resident areas needing repair. Maintenance staff will make all needed repairs to ensure that the resident areas are safe, clean and sanitary. Change to Prevent Recurrence: An Environmental Maintenance Policy and Procedure was developed and communicated to staff to ensure that ongoing monitoring of the resident areas are maintained in a safe, clean and sanitary manner. The Maintenance staff will complete a walk through monthly to identify any areas needing repairs. All staff were inserviced on 5/19/2016 on the need to report all needed repairs and/or environmental issues to the maintenance staff either verbally or written in the maintenance communication book located on each unit. Monitoring: The Maintenance Supervisor will audit the monthly walk through list to ensure all repairs are being added to the list and that the previous month's repairs have been completed. These audits will continue until	

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F 465	Continued From page 21 along the base boards to the right and left of bathroom door frame. Room 323: on the corner of the wall near the lower hinges of the bathroom door were gouged areas exposing bare wood and had sharp edges. Room 327: had a large black scuffed area on wall under toilet paper holder in the bathroom. On 5/12/16, at 8:15 a.m. during the environmental tour with the director of maintenance (DM) the above was observed. The DM stated he had lists of areas needing repair but did not have a system other than if the resident census was low or a resident moved out the room was repaired. Also if the DM heard about areas needing repair, then the area was repaired. The DM provided a log of rooms that were checked off as they are painted. A policy was requested but not provided.	F 465	the third quarter QA meeting at which time the committee will review the outcome of the audits and determine if the audits will be continued, reduced, or discontinued.	

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	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**05/10/2016**

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CORNERSTONE VILLA	**1000 FOREST STREET PO BOX 724** **BUHL, MN 55713**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cornerstone Villa was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/03/2016

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 **01 - MAIN BUILDING 1** B. WING _____	**05/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Cornerstone Villa is a one story building with no basement. It was constructed in 2003-2004. The construction type was determined to be Type V (111). This building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		6/6/16

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 _____	**05/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=F	Continued From page 2 Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect all 41 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 1:30 PM on 05/10/2016, it was observed that in the attic the smoke barrier that ran the entire length of the building was constructed of drywall on one side wood studs only. The smoke barrier is required to have a 1-hour fire resistant rating. Drywall on one side of wood studs does not have a 1-hour fire resistive rating. These deficient practices were confirmed by the Maintenance Supervisor.	K 025	Correction not needed. Cornerstone Villa has achieved a passing FSES score - see attached FSES/HC	

REPORT OF CONSULTANT FSES FINDINGS

Cornerstone Villa

1000 Forest Street, PO Box 724

Buhl, MN 55713

Provider No. 245612

Date of Survey: May 17, 2016

Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
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May 26, 2016

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

RE: FSES at Cornerstone Villa

Dear Ms. Doughty:

Enclosed please find the survey information related to the fire safety evaluation of Cornerstone Villa, 1000 Forest Street, Buhl, MN conducted on 05/17/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a smoke barrier wall (K025) deficiency cited during a fire/life safety recertification survey conducted on 05/10/2016.

The following factors served as the basis for this evaluation:

- Because the building was constructed after 03/11/2003, Cornerstone Villa was considered a new building.
- Cornerstone Villa is one story in height and has no basement. For purposes of this FSES, the building was divided into three (3) separate smoke zones.

Based on the conditions found during FSES evaluation conducted on 05/17/2016, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three (3) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Cornerstone Villa has achieved a passing FSES score.

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte
President, *Fire Safety Resources, LLC*

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: Cornerstone Villa
Address: 1000 Forest Street, PO Box 724, Buhl, MN 55713
Phone: 218-258-3253
Licensed capacity: 44
Census at time of survey: 40

Evaluator: Robert L. Imholte, President, *Fire Safety Resources, LLC*

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0900 hours and 1345 hours on 05/17/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Cornerstone Villa has achieved a passing score on the FSES.

An FSES was made necessary because of a smoke barrier wall deficiency cited during a fire/life safety recertification survey conducted on 05/10/2016. The deficiency was issued because the smoke barrier wall that runs the entire length of the building was found to be constructed of drywall on only one side of wood studs (see data tag K025). A single layer of drywall installed on one side of wood studs does not provide the 1-hour fire-resistance rating required by NFPA 101(00), Sec. 18.3.7.3.

In addition to observations made and documentation review conducted during the 05/17/2016 on-site visit, the findings outlined herein are based on:

- Information provided by Ms. Debra Doughty, Administrator, and Mr. Jeff Dobson, Environmental Services Director; and
- A review of the Statement of Deficiencies (Form CMS-2567) resulting from the fire/life safety recertification survey conducted on 05/10/2016.

Initial Comments:
The building housing Cornerstone Villa was constructed in 2003-2004 and occupied in 2004. Because the building was constructed after 03/11/2003, it is considered a new building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

The building is one story in height with an unfinished attic space and has no basement. Based on observation, interview of the Environmental Services Director and review of the Code Summary attached to the building construction drawings, the building's wood frame structural members (exterior walls, interior bearing walls and roof/ceiling assembly) are protected with materials providing a fire resistance rating of one hour. As a result, the building was assigned a Type V(111) construction type in accordance with NFPA 220(99), Sec. 3-5 and Table 3-1.

The facility has an addressable fire alarm system with manual pull stations at the exits, automatic smoke detection in the corridors, spaces open to corridors, most habitable rooms and all sleeping rooms. There are remote annunciator panels located at the main entrance and at each of the three nurse stations. The fire alarm system is monitored for automatic fire department notification. Documentation review revealed that the fire alarm system is being inspected, tested and maintained in accordance with NFPA 72.

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. A dry-pipe automatic fire sprinkler system, however, protects the attic space, combustible exterior canopy at the main entrance and the combustible overhang outside the exit to the center court located at the east side of the building. Documentation review revealed that the fire sprinkler system is being inspected, tested and maintained in accordance with NFPA 25.

Based on review of building floor plan drawings, the building is divided into four (4) areas designated as A, B, C and D:

- Area A houses a resident "neighborhood" called Tamarack. This zone consists of a nurse station, 16 resident sleeping rooms and a resident lounge/dining space.
- Area B houses a resident "neighborhood" called Birch. This zone, too, consists of a nurse station, 16 resident sleeping rooms and a resident lounge/dining space. The facility barber/beauty shop is physically located within this area, but is accessed from Area D.
- Area C houses a resident "neighborhood" called Willow. This zone consists of a nurse station, 12 resident sleeping rooms and a resident lounge/dining space.
- Area D, referred to as Support Services, houses offices, administrative and storage areas, an activity room/chapel space, a PT/OT space, and the facility's main kitchen, laundry, heating plant and receiving area.

Review of the building floor plan drawings and building construction drawings revealed that, for emergency evacuation purposes, the four (4) areas identified above are divided into three (3) smoke compartments. For purposes of this FSES, therefore, the building was divided into three (3) separate smoke zones as follows:

Zone 1 – Tamarack and Birch Units
Zone 2 – Support Services
Zone 3 – Willow Unit

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 05/17/2016. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3A (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the three (3) zones separately.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Table 8 could be checked 'Met' with the exception of Item L. Because Cornerstone Villa does not meet the definition of a high rise, Item L was checked 'Not Applicable'.

The remaining items in Table 8 were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(00), Sections 9.1 and 9.2.
- Alarms, emergency communication systems and illumination of generator set locations appeared to be powered as prescribed by NFPA 101(00), Sec. 18.5.1.2. It was reported that there are no residents on life support at Cornerstone Villa.
- No incinerator or portable space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. Cornerstone Villa is a smoke-free facility.
- Based on observation, documentation review and interview of the Administrator and Environmental Services Director, all draperies, cubicle curtains, upholstered furniture, mattresses and decorations appear to be in accordance with NFPA 101(00), Sec. 18.7.5.
- Portable fire extinguishers appeared to be provided in accordance with applicable requirements.
- EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Tamarack and Birch Units:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: There is bed capacity for up to 32 residents in this zone (16 beds each in Tamarack and Birch).
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there are two (2) staff persons on duty in this zone on the night shift (one at each nurse station in the zone).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of gypsum wallboard with wood paneling at several locations. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure approximately 142 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because, in the attic space, the smoke barrier wall between this zone and Zone 2 (Support Services) is constructed of gypsum board (drywall) installed on one side of wood studs, which does not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 18.3.7.3. It could not be confirmed at the time of this FSES survey that the construction of the ceiling assembly at which the smoke barrier wall terminates meets the exceptions to NFPA 101(00), Sec. 8.3.2 and Sec. 8.2.2.2.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected automatic smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 2 – Support Services:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". There are no sleeping rooms in this zone, but it contains an activity room/chapel space, a PT/OT space and administrative offices, which are available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that when the activity room/chapel area is occupied at full capacity, sufficient staff is present to maintain a resident/staff ratio of not more than 7:1. It was reported that a 1:1 staff ratio is maintained when residents are present in PT/OT. It was reported that this zone is not used by residents before 07:00 AM or after 08:00 PM.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents present in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of gypsum wallboard with wood paneling in the lounge area located outside the activity room/chapel. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Wood paneling was found in the Administrator's office. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating. Four (4) 22½-in. x 52-in. tempered glass vision panels were found in the corridor wall at the activity room and a 12-in. x 74-in. tempered glass sidelight was found in the corridor wall at the chapel. It was found that these spaces are now protected with automatic smoke detection to meet Exception No. 1 to NFPA 101(00), Sec. 18.3.6.1 for spaces allowed to be open to the corridor.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames. Both leaves of the set of double doors into the activity room were found to have 24-in. x 33-in. tempered glass vision panels in them. It was found that this space is now protected with automatic smoke detection to meet Exception No. 1 to NFPA 101(00), Sec. 18.3.6.1 for spaces allowed to be open to the corridor.

6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure approximately 213 ft in length and has no dead ends in excess of 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   There is a smoke barrier located between this zone and Zone 3 (Willow Unit) that serves this zone.
10. Emergency Movement Routes [Score: -2]:
    This score was assigned because, while there are multiple emergency movement routes from this zone, it was found that the leaves of the set of double exit doors, separated by a center mullion, located at the end of the corridor by the garage each measure only 33 inches in clear width. This does not meet the requirement in NFPA 101(00), Sec. 18.2.3.5 that doors in the means of egress from treatment areas have a minimum clear width of 41.5 inches. This exit serves as part of the required means of egress from PT/OT.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridor and spaces open to the corridor. The zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 3 – Willow Unit:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 12 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is one (1) staff person on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of gypsum wallboard with wood paneling at the scale alcove. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure approximately 131 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   There is a smoke barrier located between this zone and Zone 2 (Support Services) that serves this zone.
10. Emergency Movement Routes [Score: -2]:
    This score was assigned because, while there are multiple emergency movement routes from this zone, the exit access door to the main corridor was found to measure only 39 inches in clear width. This does not meet the requirement in NFPA 101(00), Sec. 18.2.3.5 that doors in the means of egress from sleeping rooms have a minimum clear width of 41.5 inches.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all sleeping rooms. Because this condition does not meet the criteria specified in NFPA 101A(01), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

* * * * * * * * * * * *

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0900 hours and 1345 hours on 05/17/2016. Any changes in those conditions after this date could affect those scores and values, either positively or negatively. Again, based on this evaluation, Cornerstone Villa **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

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

APPROVED
By Tom Linhoff at 7:34 am, Jun 06, 2016

Form Approved
OMB Exempt

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
CORNERSTONE VILLA	01-MAIN BUILDING
ZONE(S) EVALUATED: TAMARACK & BIRCH UNITS	
PROVIDER/VENDOR NO.: 245612	DATE OF SURVEY: 05/17/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	(2.0)	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	(1.5)	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.5	X	1.2	=	12.7

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	12.7	=	12.7 = 13

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert S. Imfeld, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 05/24/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff	TITLE: Fire Safety Supervisor	DATE: 06-06-2016

Form CMS-2786T (02/2013)

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0))[e]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	(10)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	(0)	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
	-14	-10	<1 hr	≥1 hr to <2 hr	≥2 hr		
			0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	(-5(0))[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 19	S_2= 16	S_3= 8	S_4= 20

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	(15)(12)[a]	4	(8)(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 19	−	S_a 11	= C 8	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 15	= E 1	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8	−	S_c 8	= P 0	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 20	−	R 13	= G 7	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	√		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code.**

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code.**

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code.* There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

APPROVED
By Tom Linhoff at 7:37 am, Jun 06, 2016

Form Approved
OMB Exempt

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
CORNERSTONE VILLA	01-MAIN BUILDING
ZONE(S) EVALUATED: SUPPORT SERVICES	
PROVIDER/VENDOR NO. 245612	DATE OF SURVEY 05/17/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	(2.0)	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor*	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.2	X	1.2	=	10.1

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R		
1.0 X	10.1	=	10.1	= 11

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X		=

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert S. Linhoff — FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 05/24/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff	TITLE: Fire Safety Supervisor	DATE: 06-06-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0))[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	(1(0))[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	(-2(0))[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	(2(0))[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	(-2)	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	(2(3))[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	**S_1= 19**	**S_2= 15**	**S_3=8**	**S_4= 20**

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 19	−	S_a 11	=	C 8	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 12	=	E 3	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8	−	S_c 5	=	P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 20	−	R 11	=	G 9	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	√		
C.	Heating and air conditioning systems conform with the air-conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code.**

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code.**

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code.* There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

APPROVED
By Tom Linhoff at 7:39 am, Jun 06, 2016

Form Approved
OMB Exempt

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Cornerstone Villa	01-Main Building
ZONE(S) EVALUATED: Willow Unit	
PROVIDER/VENDOR NO. 245612	DATE OF SURVEY 05/17/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	(3.2)	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0	1.2	(1.5)	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	(1.5)	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.5	X	1.2	=	9.5

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	9.5	=	9.5 = 10

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Vintilla – Fire Safety Resources, LLC	President	05/24/2016
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
Thomas Linhoff	Fire Safety Supervisor	06-06-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	≥1/2 to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2)0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	(10)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	(0)	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	(-2)	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 19	S_2= 15	S_3= 10	S_4= 22

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	(15)(12)[a]	4	(8)(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 19	−	S_a 11	= C 8	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 15	= E 0	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 10	−	S_c 8	= P 2	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 22	−	R 10	= G 12	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	√		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 25, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5612014

Dear Ms. Doughty:

The above facility was surveyed on May 9, 2016 through May 12, 2016 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, Health Regulation 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 Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
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 _____	05/12/2016

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) COMPLETE DATE
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		

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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 05/9/16, through 05/12/16, 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. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting services were provided as directed by the care plan for 1 of 3 residents (R28) reviewed for incontinence. Findings include: R28's Admission Record printed 5/12/16, indicated R28's diagnoses included vascular dementia, Parkinson's Disease, and hemiplegia and hemiparesis following a cerebrovascular disease (weakness/paralysis on one side of the body following a stroke). R28's quarterly Minimum Data Set (MDS) indicated R28 had a moderate impairment of cognitive skills for daily decision-making, sometimes understood communication by others and was understood by others, and required total staff assistance for transfers and toilet use. The MDS further indicated R28 did not reject care	2 565	Corrected	6/17/16

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2 565	Continued From page 3 during the assessment period for the MDS. R28's care plan dated 5/9/16, directed staff to place R28 on the toilet when voices the urge. R28's undated care guide sheet, directed staff to check R28 every 2 hours and place on the toilet when voices the urge. On 5/11/16, at 9:24 a.m. two staff entered R28's room and stated they needed to reposition R28. Nursing assistant (NA)-A and NA-D transferred R28 with a hoyer lift to the bed. R28 stated she had to have a "pee" and stated she wanted to go to the toilet. NA-D checked the brief and told R28 she was dry. During an interview immediately following cares, NA-D stated R28 has used the toilet, but usually does not go when they do put her on the toilet. NA-B stated it was uncomfortable for her to sit on the toilet. NA-A stated R28's care plan stated to check and change R28 every 2 hours. NA-A stated she may need to have a BM. On 5/12/16, at 9:22 a.m. NA-G stated sometimes R28 will ask to use the toilet and they put her on the toilet when she asks. On 5/12/16, at 10:17 a.m. the director of nursing (DON), verified staff should have toileted R28 when she asked. The DON further verified the care plan and the care guide sheets directed R28 should be put on the toilet when she asks, and the care plan was not followed. The facility policy and procedure Using the Care Plan revised 8/06, directed nursing assistants to report any changes in the resident's care plan goals and objectives that have not been met or expected outcomes that have not been achieved. The policy indicated the care plan would be used	2 565		

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2 565	Continued From page 4 in developing the resident's daily care routines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff. The DON could report the findings to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pressure-related skin conditions were identified and monitored for 1 of 3 residents (R52) reviewed for skin conditions.	2 830	Corrected	6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 5 Findings include: On 5/9/16, at 4:01 p.m. R52 was observed to have bruises on her posterior lower left arm, between the wrist and elbow. On 5/11/16, at 6:43 a.m. R52 was observed to have two bruises on the left forearm and a bruise on the outer right elbow and mid forearm. R52's Admission Record printed 5/12/16, indicated R52's diagnoses included anemia, dementia with behavioral disturbance, chronic kidney disease, and a history of falling. R52's quarterly Minimum Data Set (MDS) dated 3/12/16, indicated R52 had a severe cognitive impairment, required extensive assist of two staff for bed mobility, and extensive assist of one staff for transfers. The MDS also indicated R52 required extensive assistance of 1 staff for locomotion in the wheelchair, personal hygiene, and dressing, and had a balance impairment which required the assistance of others to stabilize her. The MDS further indicated R52 had one fall without injury since the previous MDS, had no behaviors during the assessment period for the MDS, and had no skin concerns. R52's physician orders dated 4/13/16, indicated R52 received aspirin 81 milligrams (mg) daily, which was started on 6/26/15. R52's care plan dated 7/16/15, indicated R52's skin was to be monitored daily with cares and on bath days. R52's care plan lacked documentation of R52's potential for bruising. R52's progress notes lack documentation regarding bruising on R52's arms.	2 830		

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CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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2 830	Continued From page 6 R52's bruises were not identified or monitored on the 5/16, medication administration record (MAR) and treatment administration record (TAR). On 5/11/16 at 6:41 a.m. R52 was observed propelling her wheelchair around in the hallway when she became stuck in another resident's room doorway, and at 6:43 a.m. R52 maneuvered the wheelchair out of the doorway and back into the hallway. On 5/11/16, at 7:08 a.m. R52 was observed propelling her wheelchair around in circles in the dining area, by the nurse's station. On 5/11/16, at 7:45 a.m. R52 was observed propelling her wheelchair in the hallway near her room and was ramming the wheelchair back into the walls and doorframes. On 5/12/16, at 10:03 a.m. the director of nursing (DON) stated bruises were to be monitored on the MAR or the TAR. The DON stated when bruises are found, incident reports are completed and it the bruising is investigated. The DON verified the potential for bruising would be noted on the care plan. On 5/12/16, at 10:35 a.m. nursing assistant (NA)-D stated R52's bruises were probably from bumping into walls, door frames, and other things. NA-D stated the NAs report bruises to the nurses when the bruises are found. NA-D stated she assumed R52's bruises were reported. NA-G was present during the interview and verified the same information. On 5/12/16, at 10:50 a.m. registered nurse (RN)-A measured R52's bruises on her arms.	2 830		

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	23242	A. BUILDING: _____ B. WING _____	05/12/2016

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2 830	Continued From page 7 RN-A stated bruises are usually monitored on the MAR. RN-A verified R52's potential for bruising was not on R52's care plan, and stated R52 bruises easily and bumps her arms on the walls, and other things. R52 denied pain of the bruised areas and stated she was not sure what happened when she was asked by RN-A. Measurements of R52's bruises were: Left inner forearm: 1 x 2.5 centimeters (cm) Left lower outer forearm: 1 x 0.5 cm Left upper outer: 1.2 x 2.2 cm Right elbow: #1 1.5 x 0.5 cm; #2 1.5 x 1.5 cm Right lower forearm: 2 x 1.2 cm A policy and procedure for non-pressure-related skin conditions was requested and was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies related to the identification and monitoring of non-pressure related skin issues and provide education for responsible staff. The director of nursing or designee could conduct periodic audits to ensure ongoing compliance, and review results with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		6/17/16

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2 910	Continued From page 8 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting services were provided upon resident request for 1 of 3 residents (R28) reviewed for incontinence. Findings include: R28's Admission Record printed 5/12/16, indicated R28's diagnoses included vascular dementia, Parkinson's Disease, and hemiplegia and hemiparesis following a cerebrovascular disease (weakness/paralysis on one side of the body following a stroke). R28's quarterly Minimum Data Set (MDS) assessment indicated R28 had a moderate impairment of cognitive skills for daily decision-making, sometimes understood communication by others and was understood by others, and required total staff assistance for transfers and toilet use. The MDS further indicated R28 did not reject care during the assessment period for the MDS. R28's care plan dated 5/9/16, directed staff to	2 910	Corrected	

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2 910	Continued From page 9 place R28 on the toilet when voices the urge. R28's undated care guide sheet, directed staff to check R28 every 2 hours and place on the toilet when voices the urge. R28's Bowel Assessment dated 4/2/16, indicated R28 was able to feel the urge for a bowel movement (BM) and staff were to put R28 on the toilet when she verbalized the need to go, though sometimes had already been incontinent of bowel. R28's Bladder Assessment dated 4/2/16, indicated R28 does not void when placed on the toilet, but will have a BM when placed on the toilet, when she verbalizes the need, at times. The Bladder Assessment indicated staff were to put R28 on the toilet when she verbalized the need to use it. On 5/11/16, at 9:24 a.m. two staff entered R28's room and stated they needed to reposition R28. Nursing assistant (NA)-A and NA-D transferred R28 with a hoyer lift to the bed. R28 stated she had to have a "pee" and stated she wanted to go to the toilet. NA-D checked the brief and told R28 she was dry. NA-A and NA-D pulled R28's slacks up and covered her with a blanket. During an interview immediately following cares, NA-D stated R28 has used the toilet, but usually does not go when they do put her on the toilet. NA-B stated it was uncomfortable for her to sit on the toilet. NA-A stated R28's care plan stated to check and change R28 every 2 hours. NA-A stated she may need to have a BM. The BM Sheet dated 5/11/16, indicated R28 did have a BM on that date. The NA care guide sheet dated 5/11/16, day shift indicated R28 had a BM during that shift.	2 910		

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2 910	Continued From page 10 On 5/12/16, at 9:22 a.m. NA-G stated sometimes R28 will ask to use the toilet and they put her on the toilet when she asks. On 5/12/16, at 10:17 a.m. the director of nursing (DON) verified staff should have toileted R28 when she asked. The DON further verified the care plan and the care guide sheets directed R28 should be put on the toilet when she asks, and the care plan was not followed. The facility policy and procedure for Using the Care Plan revised 8/06, directed nursing assistants to report any changes in the resident's care plan goals and objectives that have not been met or expected outcomes that have not been achieved. The policy indicated the care plan would be used in developing the resident's daily care routines. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement systems to ensure residents were toileted based on a comprehensive assessment and plan of care. The DON or designee could educate all appropriate staff. The DON or his/her designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection	21375		6/17/16

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21375	Continued From page 11 control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to failed to consistently implement contact precautions for 1 of 1 residents (R6) diagnosed with clostridium-difficile (C-diff) infection. These practices had the potential to affect all 41 residents in the facility. Findings include: The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant. R6's Consolidated Orders Report, dated 5/12/16, indicated diagnoses including muscle weakness, a history of falling, congestive heart failure, atrial fibrillation, hypertension, glaucoma, and pneumonia. On 4/27/16, the resident tested positive for C-diff. R6's quarterly Minimum Data Set (MDS) dated 4/10/16, indicated R6 was cognitively intact, but	21375	Corrected	

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21375	Continued From page 12 needed extensive assistance with activities of daily living (ADL's) including transferring, toileting, dressing and personal hygiene. R6's MDS also indicated R6 was occasionally incontinent of bladder and frequently incontinent of bowel. R6's care plan dated 2/4/16, indicated R6 required an assist of one staff person to use the toilet and to transfer, for dressing and personal hygiene. R6's care plan dated 2/4/16, indicated R6 had Clostridium difficile (C-Diff, a bacterial infection with symptoms from diarrhea to life threatening inflammation of the colon. C-diff is commonly associated with elderly who have been on an antibiotic and are in hospitals or long term care settings. C-diff is passed in feces and spread to food, surfaces and objects when people who are infections don't wash their hands thoroughly. The bacterial persists in a room for weeks or months. If someone touches a surface contaminated with C-diff you may then unknowingly swallow the bacteria. Hand sanitizer is not effective for preventing the spread of C-diff). During an observation on 5/11/16, at 7:36 a.m. nursing assistant (NA)-A was observed to answer R6's call light. NA-A donned gown, gloves and a mask and entered R6's room. NA-A assisted R6 to her wheelchair, then to the toilet in R6's room. R6 took hold of the handrails by the toilet and assisted by NA-A stood, transferred and sat on the toilet. NA-A stated there was a "little bm" in R6's brief, but she was not incontinent of urine. After R6 urinated in the toilet, NA-A wiped R6's peri-area from front to back. NA-A changed gloves without completing hand hygiene between glove changes, assist R6 to don a clean brief, flushed the toilet, assisted R6 from the toilet to the wheelchair, and then to bed. NA-A did not	21375		

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21375	Continued From page 13 remind or assist R6 with hand washing. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop, review, and/or revise policies and procedures to ensure an infection control program that includes implementation of contract precautions The director of nursing or designee could educate all appropriate staff on the policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of	21630		6/17/16

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21630	Continued From page 14 medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to ensure a policy and system had been implemented to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion. This had the potential to affect all 41 residents residing in the facility. Findings include: R28's Admission Record identified diagnoses including vascular dementia with behavioral disturbance, delusional disorders, bipolar disorders, anxiety disorders, hemiplegia and hemiparesis following cerebrovascular disease and polyarthritis. R28's quarterly Minimum Data Set (MDS) dated 4/2/16, indicated R28 had memory problems. On 5/11/16, at 1:57 p.m. the Tamarack unit medication cart was observed to have an oxycodone (a narcotic pain medication) 5 milligram (mg) medication unit dose card assigned to R28 with two tablets contained within taped over broken seal compartments. The tablets contained within the broken seal compartments lacked identifying information, and there were no signatures identifying the staff person(s) who had taped over the broken seals. On 5/11/16, at 2:00 p.m. registered nurse (RN)-B was interviewed and stated he was not aware of	21630	Corrected	

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21630	Continued From page 15 any instructions or policy regarding the disposition of narcotics contained within compromised unit dose packaging and said he would be unable to verify that the tablets within the compromised unit dose packaging were the medication as originally packaged. On 5/11/16, at 2:10 p.m. the Tamarack wing medication storage area was observed. The medication storage area had multiple containers of controlled substance medications, among which included multidose bottles of liquid morphine, liquid methadone, non-unit dose bottles of oxycodone and fentanyl patches. The list of controlled substances included the following in unit dose cards and bottles: Oxycontin 40 milligrams (mg) x 31 pills Dilaudid 2 mg (an opioid pain reliever) x 62 pills Norco (hydrocodone 10mg/acetaminophen 325 mg) x 25 pills Dilaudid 1 mg x 30 pills Oxycodone/acetaminophen 10/325 mg x 30 pills Ultram (narcotic type pain reliever) 50 mg x 213 pills Norco 5/325 mg x 70 pills Adderall (an amphetamine with addictive properties) 20 mg x 2 pills Lortab (hydrocodone/acetaminophen) 7.5/325 mg 473 milliliters (ml) x three bottles Amphetamine Salts 20 mg x 30 pills Oxycodone 5 mg x 190 pills Hydrocodone 7.5 mg x 20 pills Hydromorphone 2 mg x 39 pills Vyvanse (an amphetamine with addictive properties) 30 mg x 14 pills Temazepam (benzodiazepine used to treat insomnia) 7.5 mg x 28 pills Codeine/acetaminophen 30/300 mg x 28 pills	21630		

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21630	Continued From page 16 Tramadol 50 mg x 110 pills Hydrocodone/acetaminophen 7.5/325 mg x 47 pills Fentanyl (opioid pain reliever) patch 50 mcg/hour x 7 patches Methadone 10mg/ml (an opioid used to treat pain and ease drug withdrawal) Methadone 10mg/ml x 5 ml Morphine Sulfate 20 mg/ml x 50 ml On 5/11/16, at 2:15 p.m. RN-C and RN-B were interviewed. RN-C stated there was no policy in place directing the disposition of controlled medications. RN-B said these controlled substances may be stored for several months in the medication storage area until licensed nursing staff had time to destroy the medications together. RN-B confirmed multiple licensed nursing staff would have access to the medication storage area during the storage time awaiting medication destruction and the integrity of some of the opened medication containers could not be assured. On 5/12/16, at 10:46 a.m. the director of nursing (DON) was interviewed and stated the controlled substances contained within medication storage area were stored there as early as 2/16. The DON stated the facility planned to institute a policy of controlled substance destruction upon resident discharge from the facility. On 5/12/16, at 11:03 a.m. the consultant pharmacist was interviewed and stated he was no longer involved in the destruction of controlled medications from the facility. The consultant pharmacist said he was aware the facility had previously used a good process for the timely destruction of controlled medications, but said the procedure could get messy and lead to potential	21630		

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21630	Continued From page 17 diversion of the medications when controlled medications are stored for long periods of time. The facility's Controlled Substances policy revised 4/07, lacked direction on the handling of narcotics contained within unit dose containers with compromised seals. The facilty Discarding and Destroying Medications policy dated 4/07, lacked direction on timely destruction of controlled drugs. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures for the dispositon expired or discontinued medications. The director of nursing or designee could then perform audits to ensure proper disposition of medications, and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21630		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe and	21685	Corrected	6/17/16

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21685	Continued From page 18 homelike environment was maintained in 7 of 30 resident rooms (rooms 282, 284, 293, 296, 321, 323, 327). Findings include: On 5/12/16, beginning at 8:15 a.m. during an environmental tour, the director of maintenance (DM) verified the following environmental findings: Room 282: the bathroom walls had scuff marks along the wall. The area was the length of the walls, approximately 10 inches wide and approximately 10 inches from the floor. Room 284: a corner wall of the room near the bathroom had an area broken away exposing the sheetrock making the area rough and uncleanable. Room 293: the bathroom door had scratches in the wood. The walls in bathroom along the bottom had scrapes exposing the sheetrock making it an uncleanable surface. In addition, the bathroom and bedroom walls had black scuff marks along the bottom. Room 296: the paint on the bathroom door frame was scraped off at the bottom of the frame. The bathroom door had an area of missing laminate approximately three inches by two inches near the handle exposing rough wood. Room 321: had a large chipped area on the wall next to the bathroom door. The paint on the bathroom door frame was scraped off at the bottom of the frame. There was a large gouge along the base boards to the right and left of bathroom door frame.	21685		

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21685	Continued From page 19 Room 323: on the corner of the wall near the lower hinges of the bathroom door were gouged areas exposing bare wood and had sharp edges. Room 327: had a large black scuffed area on wall under toilet paper holder in the bathroom. On 5/12/16, at 8:15 a.m. during the environmental tour with the director of maintenance (DM) the above was observed. The DM stated he had lists of areas needing repair but did not have a system other than if the resident census was low or a resident moved out the room was repaired. Also if the DM heard about areas needing repair, then the area was repaired. The DM provided a log of rooms that were checked off as they are painted. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee could develop, review, and/or revise policies and procedures to ensure resident's environment is maintained in a safe, clean and sanitary manner. The director of maintenance or designee could educate all appropriate staff on the policies and procedures. The director of maintenance or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members.	21830		6/17/16

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	23242	A. BUILDING: _____ B. WING _____	05/12/2016

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CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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21830	Continued From page 20 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or	21830		

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21830	Continued From page 21 family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of	21830		

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21830	Continued From page 22 the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frequency of bathing preferences were honored for 2 of 3 residents (R6, R29) reviewed for choices. Findings include: R6's Admission Record identified diagnoses that included muscle weakness and congestive heart failure. R6's quarterly Minimum Data Set (MDS) dated 4/10/16, indicated R6 was cognitively intact, was totally dependent upon staff for bathing, and needed extensive assistance with activities of daily living (ADL's) including transferring. R6's care plan dated 2/4/16, indicated R6 needed an assist of one person for bathing. R6's undated bath sheet indicated R6's shower day was Monday a.m., and she had received weekly showers since 1/4/16, except when out of the facility for hospitalizations. On 5/9/16, at 5:22 p.m. R6 stated she gets one shower a week. R6 stated she would like more than one shower but "I don't get it." On 5/12/16, at 9:14 a.m. R6 again stated she gets one shower a week and she would like to have at least two a week. R6 stated they just tell you and "you take the shower when it comes." R29's Admission Record identified diagnoses that included right tibia fracture, muscle weakness and pain. R29's admission MDS dated 2/8/16,	21830	Corrected	

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21830	Continued From page 23 indicated R29 was cognitively intact, required physical assistance with bathing, and needed extensive assistance with most ADL's. R29's care plan dated 2/11/16, indicated R29 required extensive assistance with bathing. R29's undated bath sheet indicated R29's bath day was Wednesday morning, and R29 had received weekly showers from 2/3/16, through 5/4/16. On 5/11/16, at 8:11 a.m. R29 stated she was told she can only have a bath or shower once a week. When asked if she would like more than one, R29 stated "of course, who wouldn't?" During an observation on 5/11/16, at 8:16 a.m. R29 was observed requesting her bath from nursing assistant (NA)-A. At 8:19, NA-A went to fill the tub, and R29 reminded NA-A where her room was, concerned that NA-A wouldn't find her for her bath. R29 then returned to sit on the side of her bed. In an interview on 5/12/16, at 8:57 a.m., the Resident Services Director (RSD) stated one bath a week is standard unless a resident has a different preference. The RSD stated either she or the nursing staff admitting a resident will ask if a resident wants a shower or a bath. The RSD also stated she doesn't routinely offer more than one shower or bath a week. The RSD indicated care conferences occurred quarterly and provided a Care Conference Check List that indicated social services "preferences" were reviewed. The RSD also provided a Resident Preferences worksheet for use on admission and quarterly, but stated she has "fallen away" from using it, and thus does not routinely ask how many times a week a resident would like a bath or shower. The RSD stated she did not have one of these forms	21830		

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21830	Continued From page 24 from R29's admission. In an interview on 5/12/16, at 9:43 a.m. licensed practical nurse (LPN)-A stated residents are scheduled for one bath a week. LPN-A stated the facility doesn't offer more than one bath or shower a week, but if a resident or their family asks, they will accommodate more baths or showers. In an interview on 5/12/16, at 9:55 a.m. registered nurse (RN)-A stated she is often involved in resident's admission process. RN-A stated the facility schedules residents bath or shower once a week, but if someone voices they want more, they will honor the requests. RN-A stated that she doesn't typically ask if someone wants more than one. In an interview on 5/12/16, at 10:41 a.m. the director of nursing (DON) stated bathing preferences is something that is asked when a resident first comes through the door. The DON stated one bath or shower a week is standard, but a resident or family can ask for more. The DON did not think there was a document that indicated the facility told residents they could request more than one bath or shower a week. The facility policy and procedure Resident Right of Choice dated 9/13, directed upon admission and at least quarterly thereafter resident will be asked about their preferences including frequency of bathing. These preferences will be documented on Resident Preference Forms and the information will be communicated to the respective departments. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate	21830		

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21830	Continued From page 25 all employees on the need for resident's self-choice. The director of nursing or designee develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		