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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KHKN

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 **03/21/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kimberly Settergren, HFE NE II — 06/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 08/31/2017 (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
04/06/2017
(L33)

Posted 09/05/2017 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5612

On February 2, 2017, a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of G. A "G" level deficiency was cited at the previous abbreviated standard survey on August 23, 2016. The facility meets the criteria for a NOTC.

As a result of the survey findings, the Department imposed the Category 1 remedy of State monitoring, effective February 26, 2017.

In addition, we recommended the following enforcement remedy to the CMS RO for imposition and CMS RO concurred:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 2, 2017
- Civil money penalty for the deficiency cited at F314

The facility was subject to a two year loss of NATCEP beginning May 2, 2017.

On March 21, 2017, health conducted a PCR and on March 10, 2017, LSC conducted a PCR and the facility was found in substantial compliance on March 17, 2017. As a result of the revisit findings, the final status of remedies were as follows:

- Category 1 remedy of State monitoring was discontinued as of February 26, 2017.
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 2, 2017 was rescinded.
- Civil money penalty of the deficiency cited at F314 remain imposed

The two year loss of NATCEP effective May 2, 2017, will remain in effective.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245612 July 26, 2017

Ms. Debra Doughty, Administrator
Cornerstone Villa
1000 Forest Street PO Box 724
Buhl, MN 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 March 17, 2017 the above facility is certified for or recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245612

June 30, 2017
By Certified Mail

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

Dear Ms. Doughty:

SUBJECT: SURVEY FINDINGS AND IMPOSITION OF CIVIL MONEY PENALTY
Cycle Start Date: February 2, 2017

SURVEY RESULTS
On February 1, 2017, a life safety code survey and on February 2, 2017, a health survey were completed at Cornerstone Villa by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at Scope and Severity (S/S) level G, cited as follows:

- F314 -- S/S: G -- 483.25(b)(1) -- Treatment/Svcs to Prevent/heal Pressure Sores

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on February 21, 2017, of the imposition of the following remedies, as well as your appeal rights:

- State monitoring effective February 26, 2017
- Mandatory denial of payment for new admissions effective May 2, 2017

Based on the survey findings, the MDH notified you they were recommending that the CMS impose additional remedies, as follows:

- Federal Civil Money Penalty effective February 2, 2017
- Mandatory termination effective August 2, 2017

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

On March 10, 2017 and March 21, 2017, the MDH conducted revisits of your facility and found that your facility was in substantial compliance as of March 17, 2017. As a result, the final status of remedies is as follows:

- State monitoring, which was imposed effective February 26, 2017, is discontinued effective March 17, 2017
- Mandatory denial of payment for new admissions, which was to be effective May 2, 2017, is rescinded
- Mandatory termination, which was to be effective, August 2, 2017, will not be imposed

CIVIL MONEY PENALTY

On September 6, 2016 the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation CMP amounts authorized under the Social Security Act. *See* 45 CFR Part 102. In determining the amount of the Civil Money Penalty (CMP) that we are imposing for each day of noncompliance, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $710 per day for 43 days beginning February 2, 2017 and continuing through March 16, 2017 for a total of $30,530

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Tamika J. Brown at Tamika.Brown@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider’s

loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the CMP

CMP REDUCED IF HEARING WAIVED
If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification at RO5LTCHearingWaivers@cms.hhs.gov. **Please include your CCN and the Cycle Start Date in the subject line of your email.**

The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.

CMP CASE NUMBER
A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is **245612**
- The start date for this cycle is **February 2, 2017**

CMP PAYMENT
When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago

Regional Office. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR § 488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

As indicated above, a CMP which to date has accrued in the amount of $10,483 or more, is being imposed against Cornerstone Villa, therefore, this provision is applicable to your facility. If you fail to request a hearing, in writing, within 60 calendar days from receipt of this letter; or if you submit a written waiver of your right to a hearing, which results in the CMP being reduced to an amount that is still $10,483 or more; or if you timely request a hearing and there is a final administrative decision upholding the CMP in the amount of $10,483 or more, your facility is subject to a NATCEP prohibition for two years. The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $10,483 or more. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed a CMP. If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

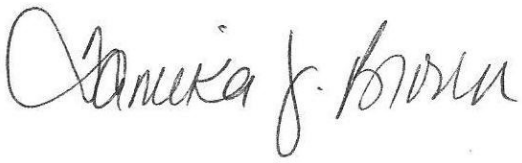
A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for Informal Dispute Resolution (IDR) following its survey visits. A request for IDR does not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,



Tamika J. Brown
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health
U.S. Department of Justice, District of Minnesota

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KHKN

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 **02/02/2017** (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 :
Kathie Killoran, HFE NEII 03/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/05/2017 (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 February 2, 2017, a standard survey was completed at the 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 the facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. As a result of the survey, the Department is imposing the following remedy:

- State Monitoring effective February 26, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314 (S/S=G). (42 CFR 488.430 through 488.444)

Furthermore, the Department recommended the enforcement remedy listed below to the CMS Region V Office. CMS concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 2, 2017 (42 CFR 488.417 (b))

The facility has requested a Fire Safety Evaluation System survey to verify a passing score for life safety code deficiency cited at:

- K0372 Subdivision of Building Spaces = Smoke Barrier

Post Certification Revisit and FSES determination to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 21, 2017

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

RE: Project Number S5612015

Dear Ms. Doughty:

On February 2, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) was cited on the current survey, whereby significant corrections were required was issued pursuant to an abbreviated standard survey completed on August 23, 2016. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 26, 2017. (42 CFR 488.422)

In addtion, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314 (S/S=G). (42 CFR 488.430 through 488.444)

Furthermore, the Department recommended the enforcement remedy listed below to the CMS Region V Office. CMS concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 2, 2017 (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 2, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 2, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Cornerstone Villa is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 2, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 May 2, 2017 (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 August 2, 2017 (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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
Email: tom.linhoff@state.mn.us
Telephone: (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
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 _____	02/02/2017

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 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		3/10/17

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

Electronically Signed | 03/03/2017

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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F 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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F 156	Continued From page 4 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 156		

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide residents of the facility with notification of all of their rights under Federal and State law. This had the potential to affect all 36 residents residing in the	F 156	Cornerstone Villa strives to ensure that all residents and/or their representatives are informed of all their rights and are aware of means to report any and all violations of these rights both through internal	

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F 156	Continued From page 6 facility, and any residents admitted to the facility. Findings include: Upon review of the facility's admission packet, the facility included an undated edited list of resident's bill of rights titled Nursing Home Resident Bill of Rights, with "Excerpts from complete bill of rights" written on the bottom of the form. On 1/31/17, at approximately 12:00 p.m. the Resident Council president (R44) stated she did not know about resident rights, and they weren't reviewed during resident council meetings. R44's quarterly Minimum Data Set (MDS) dated 12/19/16, indicated R44 was cognitively intact. R44 stated she did not know how to formally complain to the State about her care but supposed she "would write" to them. On 1/31/17, at 12:30 p.m. the social services designee (SSD)-A stated the one page Bill of Rights excerpt was part of the admission packet when she started in 2010. The SSD-A stated she had not altered the form nor downloaded the updated Combined Bill of Rights from the Minnesota Department of Health (MDH) website. The SSD-A also stated while she does review resident rights at admission, she does not review it periodically after admission. No other verbal or written information on resident rights was provided: resident rights are not reviewed individually, at care conferences or as part of resident council meetings.	F 156	reporting and externally reporting. CORRECTIVE ACTION R44 was provided with the current combined resident bill of rights packet, was informed of where and how to report a complaint/concern, and was also shown where a copy of the current combined resident bill of rights and reporting information can be easily located in a visible public area by the current "Rights" poster. CORRECTIVE ACTION AS IT PERTAINS TO OTHERS The current combined resident bill of rights has been provided to each resident and was discussed at the resident counsel meeting on 3/2/2017. The current combined Resident Bill of Rights and current contact/reporting information was placed in the main lobby by the current RIGHTS poster for residents and/or representatives to access at anytime. A letter was sent out on 2/24/2017 to each representative/family communicating the updated reporting information, where the current combined Resident Rights packet can be located. CHANGES TO PREVENT RECURRENCE Upon admission and during all annual reviews, Social Services will provide a current combined Resident Bill of Rights to each resident and/or representative per the updated Resident Rights Policy and Procedure. During the admission	

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F 156	Continued From page 7	F 156	process, the resident and/or representative will be asked to sign an acknowledgement of receipt and understanding of the Resident Bill of Rights. This offering will be added to the annual checklist to ensure a current combined Bill of Rights is provided during each annual Review. Residents and/or their representative will also be informed of the location of the current combined Resident Bill of Rights and Resident Rights poster at admission and each annual review. The Resident Bill of Rights will be discussed and made available at each resident counsel meeting. MONITORING The Administrator (or designee) will audit all admissions to ensure insure the full Resident Bill of Rights was provided and that the acknowledgement of receipt is completed. The Administrator (or designee) will audit all resident annual care conferences to ensure that the full Resident Bill of Rights was provided as well as information pertaining to the in-house location of this packet. These audits will continue until the second quarter quality assurance meeting at which time the committee will review the outcome of the audits and will determine if the audits will be continued, reduced, or discontinued.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.	F 157		3/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 8 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 157		

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F 157	Continued From page 9 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notification of room change for 1 of 1 resident (R51) reviewed for room change. Findings include: R51's Admission Record printed 2/2/17, indicated R51 was admitted from the acute care hospital to the Willow unit. R51's Diagnosis Report printed on 2/2/17, identified R51's diagnosis of dementia. On 2/1/17, at 12:42 p.m. social services designee (SSD)-A was interviewed and stated she could not find any documentation as to when R51 was transferred from the Willows unit to the Tamarack unit, and nursing should have documented in the chart when a room change occurred. SSD-A stated she does not give formal notices and does not document when residents are transferred to different rooms or units, she just calls families by phone to let them know. SSD-A stated she would have to call pharmacy and ask when R51 changed rooms. SSD-A stated she should give paper notices and keep track when residents are transferred. On 2/1/17, at 12:52 p.m. SSD-A provided the date	F 157	Cornerstone Villa strives to ensure that all residents and/or their representative are kept informed of all changes including a change of room and that this information is properly documented in the resident's permanent record. Corrective Action While resident R51 and her representative were informed of the resident room change, this information was not documented in the resident's medical record nor was the conversation regarding the room change documented in the Social Service Notes. A late entry was made in R51's medical record documenting the room change and the date of this change. Social Services made a late entry into R51's social service note documenting who was informed, the date of the discussion, date of the room change, and the new location. CORRECTIVE ACTION AS IT PERTAINS TO OTHER RESIDENTS All residents who have had recent (last 3 months) room changes were reviewed for proper documentation of the notification of the room change and that the actual change was documented in the resident	

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F 157	Continued From page 10 of room change. R51 was transferred to the Tamarack unit on 10/18/17. On 2/2/17, at 9:25 a.m. the administrator stated the protocol is to call families and talk to residents regarding room changes. The administrator stated the expectation was social services would document the conversation with family and residents when there is an agreement with a room change, and nursing should document in the chart when the room change occurs. The facility policy Room to Room Transfers dated 4/07, directed staff to document room transfers in the residents medical record.	F 157	record. All changes not containing the proper documentation will be updated. This was done by 3/3/2017. CHANGE TO PREVENT RECURRENCE A policy and procedure was developed to ensure that all residents and/or their representatives are properly notified of all room changes and that the notification is properly documented in the resident medical and social service record. Staff were inserviced on this policy and procedure on 2/9/2017. This was completed on 3/3/2017. MONITORING The Administrator (or designee) will audit all resident room changes for proper consents, documentation, and notification. These audit will continue until the second quarter quality assurance committee meeting at which time the committee will review the outcome of the audits to determine if the audits will be continued, reduced, or discontinued.	
F 226 SS=C	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to	F 226		3/10/17

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F 226	Continued From page 11 investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures related to prohibiting nursing home staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident. The failure to develop such policies/procedures had the potential to affect all 36 residents residing in the facility. Findings include: On 1/30/17, at 9:45 a.m. during the entrance conference, the administrator stated the facility did not have a social media policy or a policy on prevention of employees from taking or using	F 226	Cornerstone Villa strives to ensure that all residents are protected from all forms of resident abuse including protection from staff taking or using photographs or recordings of any and all mean which could/would demean or humiliate a resident. CORRECTIVE ACTION A Staff Social Media policy and procedure was developed and provided to all staff on 2/9/2017. All staff were inserviced on this policy and procedure on 2/9/2017. CORRECTIVE ACTION AS IT PERTAINS	

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F 226	Continued From page 12 photographs or recordings of residents. On 2/1/17, at 1:12 p.m. the administrator again verified the facility did not have a specific policy prohibiting staff from taking or using photographs or recordings of residents. The administrator stated staff received the information verbally in orientation and the information is also in an orientation video.	F 226	TO OTHERS A Staff Social Media policy and procedure was developed and will be included in all new employee orientation material. All new hires will be required to sign an acknowledgement of receipt and understanding of the Staff Social Media policy and procedure. CHANGES TO PREVENT RECURRENCE Staff Social Media Policy and Procedure will be provided to all newly hired employees and will also be provided to all employees at least annually. MONITORING Social Services (or designee) will audit all new hires to ensure that the Social Media Policy and Procedure is provided to all newly hired employees and that each new employee has signed the acknowledgement of receipt and understanding of the policy and procedure. The audits will continue until the second quarter quality assurance committee meeting at which time the committee will review the outcome of the audits and will determine if these audits will be increased, reduced, or discontinued.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination	F 278		3/10/17

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F 278	Continued From page 13 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a pressure ulcer was identified on the comprehensive assessment for 1 of 3 (R1) reviewed for pressure ulcers. Findings include: R1's quarterly Minimum Data Set (MDS) dated	F 278	Cornerstone Villa strives to ensure that all resident MDSs correctly reflect resident information during the resident scheduled observation period and that all nursing staff are trained to properly identify and document information correctly on the MDS.	

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F 278	Continued From page 14 12/15/16, with an assessment reference date of 12/1/16, indicated R1 had no pressure ulcers, but was at risk for pressure ulcers. The MDS lacked identification of the pressure ulcer identified on 12/1/16. R1's progress notes dated 12/1/16, indicated R1 had an open area on the upper buttock that measured 0.5 centimeters (cm) in diameter. R1's progress notes dated 12/15/16, indicated R1 had a Stage 3 (involving the tissue and fat layer beneath the skin) pressure ulcer on sacral area (triangular bone at base of spine) and measured 0.4 cm x 0.8 cm and had a depth of 0.1-0.2 cm. On 2/2/17, at 2:17 p.m. the director of nursing (DON) verified R1's MDS should have identified the pressure ulcer documented on 12/1/16. A facility policy and procedure for the MDS was requested but not provided.	F 278	CORRECTION R1's quarterly MDS dated 12/15/2016 was reviewed for accuracy and the pressure ulcer identified and documented on 12/1/2016 was correctly identified on a modified MDS dated 3/1/2017. CORRECTION AS IT PERTAINS TO OTHERS The MDS Policy and Procedure was reviewed and updated. Nursing staff were inserviced on the policy and procedure on 2/9/2017. RNs inserviced on identification and documentation of accurate resident information to ensure that each MDS reflects accurate information. All current MDSs were reviewed to ensure the MDS correctly reported accurate pressure ulcer documentation. This was completed by 3/3/2017. CHANGES TO PREVENT RECURRENCE All newly hired nursing staff who are responsible for the completion of the MDS will be inserviced on the MDS Policy and Procedure and will also receive formal MDS training. MONITORING The Director of Nursing Services will audit 3 MDSs weekly for accuracy. These audit will continue until the second quarterly quality assurance committee meeting at which time the committee will determine if the audits will be increased, decreased, or discontinued.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		3/17/17

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F 280 SS=D	Continued From page 15 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 16 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 17 assessments. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to ensure the care plan was revised to reflect nutritional interventions to promote the healing of pressure ulcers for 1 of 3 residents (R54) reviewed for pressure ulcers. In addition, the facility failed to ensure the care plan was revised to include interventions to reduce or prevent weight loss for 1 of 3 residents (R51) reviewed for nutrition. Findings include: R54's Diagnosis Report printed 2/1/17, indicated R54's diagnoses included a left artificial hip, dementia, muscle weakness, and adult failure to thrive. The care plan dated 3/13/15, indicated R54's weight had been stable the past six months and R54's intake was adequate to meet his needs. The care plan lacked nutritional interventions to promote healing of pressure ulcers. A progress note dated 11/3/16, indicated the pressure ulcer measurement consisted of: left heel suspected deep tissue injury (SDTI) 3.5 centimeter (cm) by 6 cm. Left buttock SDTI measured 6 cm by 4.5 cm with a superficial open area with a red center that measured 4 cm by 2 cm. The annual Minimum Data Set (MDS) dated 12/31/16, indicated R54 had one SDTI and one Stage 4 pressure ulcer. R54 had pressure reducing devices on the bed and in the wheelchair and was on a turning and	F 280	Cornerstone Villa strives to ensure that all resident care interventions are clearly documented in the residents' individualized plan of care. CORRECTIVE ACTION R51's and R54's plan of care were reviewed and updated to include the nutritional interventions on 2/6/2017. These interventions have been discussed with the resident R54 and R51 (and/or representative). Both R51 and R54 progress and interventions are discussed at the weekly high risk committee meetings. CORRECTIVE ACTION AS IT PERTAINS TO OTHERS The Resident Plan of Care policy and procedure as well as the Prevention of Pressure Ulcer P&P were reviewed and updated on 2/3/2017 and presented to the department managers on 2/3/2017 and at the mandatory inservice on 2/9/2017. All resident care plans were reviewed and updated to ensure that all current nutritional interventions were clearly documented and implemented. CHANGES TO PREVENT RECURRENCE The High Risk committee will meet weekly to discuss all residents realizing a significant weight loss, per the updated Weight Loss Policy and Procedure, as well as residents assessed at high risk for	

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F 280	Continued From page 18 repositioning program. R54 did not have any nutrition or hydration interventions to manage skin problems. The Nutrition Care Area Assessment (CAA) dated 1/11/17, indicated R54 required extensive assistance with bed mobility, had a Stage 4 pressure ulcer on the left buttock, and a SDTI on the left heel. R54 was being seen by the wound clinic. R54's protein was adequate to assist in healing. The CAA further indicated the dietary director would speak with the consultant this month for other possible interventions. The Annual Nutrition Review dated 1/11/17, indicated R54's chart and care plan were reviewed. R54 had pressure ulcers and was below nutrition baseline. The dietary services director would consult with the registered dietitian to determine possible interventions for weight loss and pressure ulcers. On 1/12/17, the progress notes indicated the facility received a new order for nutritional supplement per dietary recommendations due to a 12 pound weight loss in the past month and to aid in wound healing. In addition, the physician ordered a multivitamin with minerals and vitamin C. However, this intervention was not added to the care plan, but was implemented. On 1/25/17, the progress notes indicated zinc was ordered for two weeks and dietary would add extra protein to promote wound healing. However, this intervention was not added to the care plan, but was implemented. On 2/1/17, at 2:06 p.m. the dietary manager (DM)-A stated if a resident had a pressure ulcer	F 280	pressure ulcers. Nutritional interventions will be discussed and all implemented interventions will be documented in the individualized resident plan of care for those resident identified at high risk. All recommended interventions will be discussed with the resident and/or representative prior to being implemented and/or added to the resident plan of care. MONITORING The Director of Nursing (or designee) will audit all additional nutritional interventions implemented weekly to ensure each intervention has been discussed with the resident and/or representative, intervention has been implemented and are included in the resident plan of care. These audits will continue until the second quarter quality assurance committee meeting at which time the committee will determine base on the outcome of the audits if these will be continued, decreased, or discontinued.	

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F 280	Continued From page 19 she would make sure the resident was getting enough protein and calories to help it heal and add zinc to the diet. DM-A would also discuss it with the dietitian. R54 had not been, so DM-A consulted with dietician. DM-A further stated R54's protein was increased, and when R54 lost weight a nutritional supplement was added. DM-A stated she finds out about pressure ulcers from morning report or the wound nurse will tell her. When a resident returned from hospital or there was a new admission, the DM-A reviewed the resident's history and physical. DM-A stated she was unsure when she was made aware of R54's pressure ulcer. The facility's Prevention of Pressure Ulcers policy dated 3/05, directed the dietitian would assess the resident's nutrition and hydration and make recommendations based on the individual assessment.	F 280		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		3/17/17

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F 314	Continued From page 20 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and services were provided to reduce or prevent the development of, or worsening of pressure ulcers for 2 of 3 residents (R54, R1) reviewed for pressure ulcers. This resulted in actual harm for R54. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is	F 314	Cornerstone Villa strives to ensure that all resident at risk of skin breakdown/pressure ulcers are promptly identified and receive the proper interventions to reduce the risk of breakdown and/or to ensure residents receive the services and necessary treatment to promote healing and prevent new ulcers from developing. CORRECTIVE ACTION R54 plan of care has been reviewed and revised to include all necessary interventions to promote healing of the current pressure ulcers, prevent infections and new ulcers from developing. R54 is seen at least weekly, or more if needed, by a RN to assess the healing progress and to determine if the current treatment and interventions are effective and to determine if other interventions are needed. R54's healing progress, effectiveness of interventions, and nutritional status are discussed weekly at the high risk committee meeting to ensure his needs are being met to promote healing and prevent infection and/or new ulcers from developing, and to discuss effectiveness of current inventions. All interventions, including nutritional and hydration, have been added to the resident plan of care and care sheets have been updated to reflect the interventions/resident plan of care.	

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F 314	Continued From page 21 an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R54's Diagnosis Report printed 2/1/17, indicated diagnoses that included left hip fracture with a left artificial hip, muscle weakness, and adult failure to thrive.	F 314	A Skin Ulcer Risk Assessment and Care Plan Tool was completed for R1 on 2/19/2017 during the quarterly review process and again on 3/2/2017. This assessment includes a summary of skin problems and risk factors for determining R1's level of risk. A Braden Scale was also completed for R1 on 2/19 and again on 3/2/2017. R1 has been added to the weekly high risk committee list for weekly review and monitoring. The committee will review effectiveness of current interventions and recommendations for additional interventions. All resident plans of care will be reviewed to ensure that all interventions are documented and implemented. CORRECTIVE ACTION AS IT PERTAINS TO OTHERS The Prevention of Pressure Ulcer policy was reviewed and updated on 2/8/2017 to include direction on frequency of pressure ulcer assessments and the nursing staff were inserviced on the revised policy on 2/9/2017. A new Skin Ulcer Risk Assessment and Braden Scale will be completed on all current residents by 3/6/2017. The pressure ulcer risk level for all residents will be provided to the high risk committee for review to determine effectiveness of current interventions and to determine if additional interventions are to be implemented including nutritional interventions. All interventions will be added to the resident individualized plan of care. Changes to Prevent Recurrence	

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F 314	Continued From page 22 R54's quarterly Minimum Data Set (MDS) dated 10/1/16, indicated R54 had moderate cognitive impairment, and was independent with bed mobility, transfers, ambulation, dressing, toileting and personal hygiene. The MDS further indicated R54 was not at risk for, and did not have any pressure ulcers. On 10/24/16, a progress note indicated R54 returned to the facility from the hospital due to a left hip fracture. On 10/24/16, a Skin Ulcer Risk Assessment and Care Plan Tool indicated R54 had no history of pressure ulcers, and no skin problems were identified. The Braden Scale (for predicting pressure ulcer risk) dated 10/24/16, indicated R54 was low risk for pressure ulcers. On 10/25/16, a progress note indicated R54 had no special treatments, and had routine skin care. On 10/26/16, a Bed Tissue Tolerance Test (a test to determine the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) determined R54 needed to be repositioned every two hours or when needed. On 10/31/16, a 5 day MDS indicated R54 required extensive assistance from staff with bed mobility, transfers, dressing and toileting. The MDS identified R54 had not ambulated. The MDS further indicated R54 did not have a pressure ulcer, but he was at risk for pressure ulcers, and had a pressure reducing device in the chair. The MDS indicated R54 did not have a pressure reducing device on his bed and he was not on a	F 314	Per the revised Prevention of Pressure Ulcer policy, Skin Ulcer Risk Assessments and Braden Scales will be completed in their entirety upon admission X3, re-admission X3, and at a minimum of quarterly thereafter. The outcome of these assessments will be discussed at the interdisciplinary care conference meeting and risk level will be documented on a risk level flow sheet that will be reviewed at the weekly high risk meeting. Residents assessed to be at high risk for skin ulcers will be followed by the high risk committee until which time they are assessed by an RN to longer be at high risk. MONITORING The Director of Nursing will audit two (2) admissions and two (2) quarterly reviews weekly to ensure that the Skin Ulcer Risk Assessments and Braden Scales are completed in their entirety and the determined risk factor is documented on the risk level flow sheet and the high risk committee reviews and discusses weekly each newly documented risk level. All residents assessed to be at high risk for skin ulcers will be added to the list of residents to be followed at the weekly committee meeting. These audits will continue until the second quarterly quality assurance committee meeting at which time the committee will determine if these audits will be increased, decreased, or discontinued.	

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F 314	Continued From page 23 turning and repositioning program. On 11/2/16, a progress note identified R54 had a suspected deep tissue injury (SDTI) on the left heel that measured approximately 3 centimeters (cm) by 5.6 cm. The progress note also identified R54's left buttock had a red area that measured 6 cm by 2.4 cm, with an open area within that measured 2.4 cm by 2.2 cm. A progress note also indicated the physician was updated on the pressure ulcers, an Allevyn (a padded adhesive dressing) was was ordered, and an air mattress was provided for R54's bed. On 11/3/16, a progress note identified the pressure ulcer measurement consisted of: left heel SDTI 3.5 cm by 6 cm. Left buttock SDTI measured 6 cm by 4.5 cm, with a superficial open area with a red center that measured 4 cm by 2 cm. On 11/6/16, a progress note indicated the pressure ulcer measurement on the buttock was worse, and measured 6.2 cm by 4.8 cm. The pressure ulcer had a foul smell and black areas. The MD gave an order for R54 to be seen at the wound clinic. On 11/7/16, the 14 day MDS indicated R54 continued to require extensive staff assistance with bed mobility, transfers, dressing, and toileting. The MDS indicated R54 ambulated with extensive staff assistance. The MDS further indicated R54 was at risk for pressure ulcers, and had two Unstageable pressure ulcers that were not present on the prior assessment. The MDS identified R54 had pressure reducing devices on the bed and in the wheelchair, but was not on a turning and repositioning program, and did not	F 314		

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have any nutrition or hydration interventions to manage skin problems.

On 11/10/16, a Nursing Home/Clinic Transfer Form indicated R54 had been seen at the wound clinic. Orders included to reposition every him two hours when sleeping and every one hour when awake, offload as much as possible, wear heel protectors in bed, and encourage R54 to use his hands to move the wheelchair and not his feet. The left buttock was a Stage 2 pressure ulcer and the left heel was an Unstageable pressure ulcer.

On 11/16/16, a progress note indicated R54 left for a wound clinic appointment. On 11/17/16, a progress note indicated the facility called the wound clinic for an update on R54. R54's pressure ulcer on his left hip had been debrided, and R54 had been admitted to the intensive care unit (ICU) for intravenous (IV) antibiotics due to an infection in the pressure ulcer.

On 11/20/16, R54 returned to the facility. A Braden Scale determined R54 was low risk for pressure ulcers. An Admission Skin Assessment was completed and identified R54's left heel SDTI, and the Stage 3 pressure ulcer on the left buttock. On 11/21/16, a Bed Tissue Tolerance Test was performed and determined R54 needed to be repositioned every two hours at night and every one hour when awake.

On 11/27/16, a 5 day MDS indicated R54 had one Stage 3 pressure ulcer and one Unstageable pressure ulcer. R54 had pressure reducing devices on the bed and in the wheelchair, and was on a turning and repositioning program. The MDS indicated R54 did not have any nutrition or

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F 314	Continued From page 25 hydration interventions to manage skin problems. On 11/28/16, a progress note indicated R54's left buttock pressure ulcer had worsened to a Stage 4 pressure ulcer. The pressure ulcer measured 3.7 cm by 2.5 cm, and was three inches deep. R54 had a wound clinic appointment the next day. On 11/29/16, the Wound Clinic Transfer Form dated 11/29/16, indicated the ROHO cushion in the wheelchair needed to be evaluated and inflated as it was bottoming out. On 12/4/16, R54's 14 day MDS dated 12/4/16, indicated R54 had one SDTI and one Stage 4 pressure ulcer. R54 had pressure reducing devices on the bed and in the wheelchair, and was on a turning and repositioning program. The MDS identified R54 did not have any nutrition or hydration interventions to manage skin problems. On 12/6/16, the Wound Clinic Transfer Form indicated the ROHO cushion was not relieving the pressure and needed to be replaced. A 12/12/16, a late entry progress note (did not provide the correct date for the note) indicated the left buttock pressure ulcer was a Stage 4 and measured 3.5 cm by 2 cm and was 3 inches deep. The pressure ulcer had undermining (deep tissue damage around the wound margin) through the whole wound that measured 0.5 cm to 2.4 cm. The left heel SDTI measured 4 cm by 5.6 cm. On 12/16/16, a Wound Clinic Transfer Form directed to increase the dressing changes to three times a day. The wound clinic spoke with therapy about inflating the ROHO cushion.	F 314		

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On 12/19/16, a progress note indicated the left heel SDTI measured 3.2 cm by 3.8 cm and was decreasing in size. The left buttock pressure ulcer measured 3 cm by 1.5 cm by 3.2 cm and had tunneling (a narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation) measured 4.5 cm.

On 12/20/16, R54's 30 day MDS indicated R54 had one SDTI and one Stage 4 pressure ulcer. R54 had pressure reducing devices on the bed and in the wheelchair, and was on a turning and repositioning program. R54 did not have any nutrition or hydration interventions to manage skin problems.

A 12/26/16, a late entry (did not provide the correct date for the note) indicated the left buttock pressure ulcer was a Stage 4 and measured 2.5 cm by 1.8 cm by 3.7 cm. The tunneling measured 4.8 cm. The note further indicated Occupational therapy had replaced R54's wheelchair base seat the previous week.

The care plan dated 12/29/16, indicated R54 had a Stage 4 pressure ulcer on the left gluteal (buttocks) and SDTI on the left heel. R54 was at risk for further pressure ulcers related to impaired mobility. The care plan directed staff to administer treatments as ordered and monitor for effectiveness, alternating pressure mattress on the bed, ROHO (air) cushion on the wheelchair, assist R54 to turn and reposition at least every two hours and more often as needed or requested when in bed, and every one hour when in the wheelchair, monitor nutritional status, serve diet as ordered, monitor and record intake,

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monitor, document and report to the physician any changes in skin status, and wears a left heel boot.

The nursing assistant (NA) care sheet (not dated) indicated R54 was to have a heel lift boot on the left foot when in bed, the wheelchair and during transfers. The care sheet did not direct how often to reposition R54.

On 12/31/16, R54's annual MDS indicated R54 had one SDTI and one Stage 4 pressure ulcer. R54 had pressure reducing devices on the bed and in the wheelchair, and was on a turning and repositioning program. R54 did not have any nutrition or hydration interventions to manage skin problems.

On 1/1/17, the Pressure Ulcer Care Area Assessment (CAA) R54 required extensive staff assistance with bed mobility, and had a current Stage 4 pressure ulcer on the left buttock, and a SDTI on the left heel. The wounds were being managed by the wound clinic. Nursing was to change the dressings as ordered, and monitor the wounds for signs and symptoms of infection or worsening condition. R54's goal was that he would be free from further pressure related skin injury through the next review. The CAA failed to comprehensively assess R54's risk for pressure ulcers, and his current pressure ulcers.

On 1/11/17, the Nutrition CAA indicated R54 required extensive assistance with bed mobility and had a Stage 4 pressure ulcer on the left buttock, and a SDTI on the left heel. R54's protein was adequate to assist in healing. The CAA further indicated the dietary director would speak with the consultant this month for other

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possible interventions.

On 1/12/17, the progress notes indicated the facility received a new order for nutritional supplement per dietary recommendations due to a 12 pound weight loss in the past month, and to aid in wound healing. In addition the physician ordered a multivitamin with minerals and vitamin C.

On 1/13/17, the progress notes indicated the facility spoke with the wound clinic about miscommunication for the wound treatment as the pressure ulcer on the buttocks appeared to be closing from the outside. Treatment orders were changed to wet to dry dressings due to that was the treatment the facility was doing while they were out of the Mesalt (a sodium chloride impregnated gauze). R54's next appointment was changed from 1/25/17 to 1/16/17.

On 1/25/17, the progress notes indicated the pressure ulcer on the buttocks had an exposed tendon present, and the remainder of the pressure ulcer was 100% red beefy tissue. The pressure ulcer measured 1.2 cm in length, 0.8 cm in width and was 2 cm deep. Tunneling was 4 cm deep. Undermining was present and was approximately 1.2 cm. The inside of the ulcer was healing slowly and the outer ulcer opening edges were rolling and contracting. The left heel pressure ulcer measured 2.8 cm long by 3.5 cm wide. The ulcer was slowly decreasing in size. Zinc was ordered for two weeks and dietary would add protein.

On 1/31/17, the director of nursing (DON) entered a progress note that indicated R54's repositioning in the bed and the wheelchair was changed to

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every two hours per the 11/20/16, hospital discharge orders. This was an increase in the repositioning time while up in the wheelchair, despite the deterioration in the pressure ulcers, and was not based on an assessment.

On 1/31/17, R54 had continuous observation from 5:30 p.m. until 6:10 p.m. At 5:30 p.m. R54 was observed up in the wheelchair in the unit dining room for supper. A heel lift boot was on the left foot. At 5:50 p.m. R54 removed himself from the dining area and returned to his room. An alternating pressure mattress was observed on the bed. At 6:10 p.m. R54 was assisted to the toilet by staff and then returned to the wheelchair.

On 2/1/17, R54 had continuous observation from 7:00 a.m. until 8:40 a.m. At 7:00 a.m. R54 was observed up in the wheelchair in the unit dining room for breakfast. At 7:45 a.m. R54 exited the dining room, was weighed, brought to his room by staff and remained up in the wheelchair. At 8:23 a.m. nursing assistant (NA)-A assisted R54 on to the toilet. A properly inflated ROHO cushion was observed on the seat of the wheelchair. NA-A then assisted R54 onto the bed and positioned R54 onto the right side. The heel lift boot remained on the left foot. At 8:40 a.m. R54 requested to get up in the wheelchair. NA-A assisted R54 into the wheelchair.

On 2/1/17, at 2:41 p.m. R54's pressure ulcers were observed. The pressure ulcer on the buttock measured 0.9 cm long, 0.9 cm wide with 4 cm tunneling and 2.1 cm undermining. The pressure ulcer appeared to be a hole on the left buttock with rolled edges. The left heel pressure ulcer had a round black area with lifted edges that covered the entire heel.

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F 314	Continued From page 30 On 2/1/17, at 12:39 p.m. NA-B stated R54 had a pressure ulcer on his buttocks. NA-B stated R54 was to be repositioned every two hours and R54 liked a pillow under the left hip when in the wheelchair to get some of the pressure off and his foot was to be on the foot rest. NA-B further stated R54 did not complain of pain very often. If he has pain he requests to get off of his buttocks. On 2/1/17, at 1:05 p.m. NA-A stated he takes care of R54 the most. NA-A stated R54 had a pressure ulcer on his buttocks. R54 was to be turned and repositioned every two hours unless he requested to be repositioned more often. R54 did not complain of pain. R54 will request to get off of his buttocks because he is tired of sitting. NA-A further stated sometimes R54 will stay laying down for five minutes and sometimes he will lay down for an hour. R54 always lays on his right side and does not complain of heel pain. On 2/01/17, at 12:41 p.m. licensed practical nurse (LPN)-B stated R54 had a pressure on the left side of his buttocks and was seen at the wound clinic. LPN-B stated R54 had a circulating air mattress on the bed and special cushion in the wheelchair. R54 was to be repositioned every two hours when in bed and in the wheelchair. LPN-B stated R54 did not complain of pain during the pressure ulcer treatment. On 2/1/17, at 1:18 p.m. the DON stated skin risk assessments and the Braden Scale were done on admission, re-admissions, weekly for four weeks and quarterly. The assessments were completed by the floor nurse, either a licensed practical nurse (LPN) or a registered nurse (RN). If a resident was at risk for pressure ulcers an	F 314		

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additional air mattress would be added to the bed, a cushion would be added to the wheelchair, and the resident would be repositioned as assessed by the Tissue Tolerance Test. The DON further stated if a resident had a pressure ulcer, the facility would fill out an incident report, notify the physician and ask for a referral to the wound clinic. The DON was informed R54 returned from the hospital on 10/24/16. The DON verified the MDS dated 10/31/16, indicated R54 did not have any pressure ulcers and was at risk for pressure ulcers, lacked a pressure reducing device on the bed, and was not on a turning and repositioning program. The DON stated she would expect the device on the bed and the repositioning program. The DON verified R54's skin broke down on 11/2/16, and an air mattress was placed on the bed that day. The DON verified the 14 day MDS dated 11/7/16, indicated R54 had two Unstageable pressure ulcers, he was not on a turning and repositioning program, and did not have any nutritional interventions. The DON stated turning and repositioning should have been implemented at that time. The DON further verified R54 was hospitalized and received intravenous (IV) antibiotics for the wound on 11/17/16. The DON verified the five day MDS dated 11/27/16, identified a turning and repositioning program, but lacked nutrition or hydration interventions to manage skin problems. The DON stated dietary was informed of the pressure ulcer and should have assessed R54. The DON verified the 14 day MDS dated 12/4/16, the 30 day MDS dated 12/20/16, and the annual MDS dated 12/31/16, lacked nutrition and hydration interventions. The DON verified a nutritional supplement, a multivitamin with minerals and vitamin C was added on 1/12/17, for wound healing. When asked if it was common

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practice to notify the dietitian two and a half months following the development of a pressure ulcer, the DON did not respond. The DON stated she changed R54's repositioning to every two hours when awake on 1/31/17, following review of his chart, and verified it was not based on an assessment. The DON stated R54 was laying down on days and afternoons as it made it easier for R54 to attend activities.

On 2/1/17, at 1:44 p.m. the occupational therapist (OT) stated R54's wheelchair seat was evaluated, and a hard pan seat was placed on the wheelchair. The OT stated the ROHO cushion contracted when R54 was going to the wound clinic due to the cold outside temperatures. The OT further stated the ROHO cushions were checked daily, and staff tried to get R54 out of the chair and walk, but R54 liked to spend a lot of time in the wheelchair.

On 2/1/17, at 2:06 p.m. the dietary manager (DM)-D stated if a resident had a pressure ulcer she would make sure the resident was getting enough protein and calories to help it heal. The DM-D stated she would also add zinc to the diet, and would discuss it with the dietitian. The DM-D further stated R54's protein was increased, and when R54 lost weight a nutritional supplement was added. The DM-D stated she finds out about pressure ulcers from morning report, or the wound nurse will tell her. The DM-D stated she reviewed the history and physical when a resident returned from the hospital, or when there was a new admission. The DM-D stated she was unsure when she was made aware of R54's pressure ulcer.

On 2/1/17, at 3:15 p.m. the DM-D stated she

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

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F 314	Continued From page 33 became aware of R54's pressure ulcers when reviewing the progress notes for the annual MDS. On 2/2/17, at 11:38 a.m. the DM-D stated the facility had a monthly high risk meeting where weight loss and skin issues were discussed. The DM-D further stated R54 was discussed at the 1/31/17, meeting, but not prior. R54 was brought up at the meeting due to the pressure ulcers, an acute illness, recent hip fracture, and a weight loss of 12 pounds in December, 2016. The facility's Prevention of Pressure Ulcers policy dated 3/05, indicated the purpose of the policy was to provide identification of pressure ulcer risk factors and intervention for specific risk factors. The policy further directed to when in bed, change the resident's position every two hours or more frequently if needed, and determine if the resident needs a special mattress. For a resident in a chair, change the position at least every hour and use a gel or air cushion to relieve pressure. The dietitian would assess the resident's nutrition and hydration and make recommendations based on the individual assessment. R1's quarterly Minimum Data Set (MDS) assessment dated 12/15/16, indicated R1 had a	F 314		

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severe cognitive impairment, required extensive assist of one staff for bed mobility, transfers, and toilet use. R1 was frequently incontinent of bladder and occasionally incontinent of bowel. R1's MDS further indicated R1 was at risk for pressure ulcers.

R1's Admission Record printed 2/2/17, indicated R1's diagnoses included muscle weakness, hemiplegia and hemiparesis (muscle weakness and limited movement on one side of the body), a cerebral infarction (stroke), anemia, diabetes, and dementia.

R1's care plan dated 8/25/14, indicated R1 was at risk for potential pressure ulcers related to immobility and history of pressure ulcers, and had an actual Stage 3 pressure ulcer on the sacral area. R1's care plan with interventions dated 8/25/14, directed staff to monitor nutritional status and intake, and record, and to monitor skin with daily cares and on bath days, and turn and reposition R1 every 2 hours. The nurse and physician were to be notified of changes in skin. R1's care plan with interventions dated 12/29/16, directed staff to ensure a pressure reducing wheelchair cushion and circulating air mattress were in place. The care plan further directed nursing to provide treatment as ordered and notify the physician if signs and symptoms of infection and worsening of the pressure ulcer, or if it were not healing.

R1's progress notes dated 12/1/16, indicated R1 had a new pressure ulcer on the upper buttocks, measuring 0.5 centimeters (cm) in diameter.

R1's progress notes documentation lacked monitoring of the new pressure ulcer until

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12/15/16. R1's progress notes dated 12/15/16, indicated R1 had a Stage 3 pressure ulcer, measuring 0.4 cm x 0.8 cm with a depth of 0.1 to 0.2 cm. The pressure ulcer floor was 40% slough (yellow, dead tissue that adheres to the ulcer floor). The progress notes further indicated an Allevyn dressing (a dressing used for chronic wounds to help protect the ulcer and provide the proper environment to promote healing) was applied.

R1's electronic medical record (eMAR) dated 12/28/16, indicated R1's pressure ulcer was decreasing in size and measured 0.4 cm x 0.4 cm and had a depth of 0.1 cm, and the slough was absent. The note further indicated the pressure ulcer floor was 100% red granulation tissue (new tissue that forms on the surface of the wound during healing). The documentation indicated a new Allevyn dressing was applied and Bacitracin (a topical antibiotic ointment) was added to help with moisture and redness.

R1's progress notes dated 1/2/17, indicated the pressure ulcer was closed. An Allevyn dressing was applied to the fragile tissue.

R1's progress notes dated 1/20/17, indicated R1's sacral pressure ulcer continued to be healed.

R1's electronic treatment administration record (eTAR) for 12/16, indicated barrier cream with incontinence cares was initiated on 12/1/16, and was put on hold on 12/15/16. The eTAR indicated an Allevyn dressing to sacral area was initiated on 12/15/16, and the eTAR for 1/17, indicated the Allevyn dressing was last applied on 1/9/17.

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R1's Skin Ulcer Risk Assessment and Care Plan Tool dated 5/7/16, lacked a summary of skin problems and risk factors to determine whether R1 was at risk for pressure ulcers.

On 2/2/17, at 11:21 a.m. the dietary manager (DM)-D, stated she did not recall if she had heard that R1 had a pressure ulcer, and verified there was not a formal notification of skin breakdown to the dietary department. DM-D stated she hears in morning report, and then she reviews the intake to make sure it is appropriate. DM-D verified the facility does not have interdisciplinary team meetings to discuss residents with skin breakdown, but stated they have a high risk nutrition meeting to address those nutritionally at risk. DM-D verified she makes notes from meetings in a notebook, and does not enter notes in the electronic medical record. DM-D stated she did not think they had discussed R1 during these meetings.

On 2/2/17, at 11:41 a.m. DM-D verified R1 had not been discussed during their high risk meetings.

On 2/2/17, at 2:17 p.m. the director of nursing (DON) stated residents with skin breakdown would normally be looked at to make sure they are getting enough nutrition and protein and would be added to the high risk meetings. The DON verified R1 had a history of pressure ulcers on her buttocks, and had the cushion and circulating air mattress on the bed prior to the most current pressure ulcer. The DON stated the registered nurse (RN) reviewed the cushions after the pressure ulcer developed to make sure there were no pressure areas on the cushions, but verified therapies had not evaluated R1 for

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F 314	Continued From page 37 positioning or for cushions. The DON stated the interventions were still appropriate because R1's pressure ulcer healed quickly, though she verified the pressure ulcer had worsened between identification on 12/1/16, and documentation on 12/15/16, when the Alevyn dressings were initiated. The DON verified there should have been monitoring, documentation, and treatment of the pressure ulcer between 12/1/16, and 12/15/16. The facility's Prevention of Pressure Ulcers policy dated 3/05, lacked direction on frequency of pressure ulcer assessments.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based observation, interview, and document	F 325	Cornerstone Villa strives to ensure that all	3/17/17

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F 325	Continued From page 38 review, the facility failed to ensure the care plan was revised to include interventions to reduce or prevent weight loss for 1 of 3 residents (R51) reviewed for nutrition. Finding include: R51's Diagnosis report printed on 2/2/17, identified diagnoses of displaced intertrochanteric fracture of right femur and right pubis, dementia, chronic pain, and gastro-esophageal reflux. R51's quarterly Minimum Data Set (MDS) dated 11/12/16, indicated R51 had moderate cognitive impairment, was independent with eating, had not been on a weight loss or weight gain program, and was on a regular diet. R51's Nutrition/Hydration Review note dated 8/29/16, indicated R51 received a regular diet, ate and drank independently after set-up, consumed 61-73% of all foods and fluids offered, and met estimated calorie needs of 1276 calories/day. R51's care plan dated 9/2/16, identified R51's intake had been adequate to meet needs, and directed staff to monitor intake each meal, monitor weight monthly, and observe for signs and symptoms of dehydration. R51's care conference note dated 12/1/16, indicated R51's current weight was 112 pounds (lbs) down 4 lbs since admission, her meal intake was less than 75%, which met her needs, and her usual body weight (UBW) was 100-115 lbs. No concerns. R51's Weights and Vitals Summary dated 2/2/17, identified the following weights for R51:	F 325	residents at risk for nutritional and hydration problems are promptly identified. Those identified in this risk group will have interventions implemented which will be discussed with the resident/representative and documented on the resident plan of care. CORRECTION R51 was reweighed to determine accuracy of documented weight. Documentation of R51's intakes were began immediately, R51 was added to the list of high risk residents to be followed at the weekly high risk committee meeting on 2/6/2017: between meal nutrition is being offered, intakes documented, AM and PM supplements provided. PM nutrition is being offered and intakes documented. R51 will be weighed weekly and discussed at the weekly high-risk nutritional meeting. Interventions will be adjusted based on resident daily intakes and weights. CORRECTION AS IT PERTAINS TO OTHERS A Weight Loss Policy and Procedure was developed and all staff were inserviced on 2/9/2017 All residents were weighed to verify documented weight accuracy. All residents with a weight loss/gain of => 5% in 30 days or 10% in 6 months were added to the weekly high risk nutrition list of resident to discuss. These residents are also being weighed weekly and interventions put in place and documented in the resident plan of care.	

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F 325	Continued From page 39 8/20/16: 116 lbs 9/5/16: 112 lbs 10/1/16: 111 lbs 11/1/16: 112 lbs 12/1/16: 105 lbs (10% weight loss from 8/20/16) 1/2/17: 106 lbs R51's Amount Eaten record dated 1/2/17, through 2/2/17, indicated 29 out of 32 days R51 refused breakfast, 6 out of 31 days R51 consumed 26-50% of lunch, 5 out of 32 days R51 consumed 51-75% of lunch, 20 out of 31 days R51 consumed 76-100% of lunch. At dinner, 10 days are blank, 8 out of 31 days R51 consumed 26-50%, 2 out of 31 days R51 consumed 51-75%, 11 out of 31 days R51 consumed 76-100%. On 1/31/17, at 5:30 p.m. R51 was observed in the dining independently eating, and consumed 100% of meal. On 2/1/17, at 8:33 a.m. R51's call light was on. Nursing assistance (NA-D) answered the call light and asked R51 if she wanted to go to breakfast. R51 declined, and requested to go back to bed, transferring herself back to bed with stand by assistance from NA-D. On 2/1/17, at 8:40 a.m. NA-D was interviewed and stated R51 preferred to sleep in, and does not come out for breakfast. At 8:49 a.m. R51 was in her room sleeping in bed. R51 had not come out of room for breakfast and no food was brought to room. On 2/2/17, at 9:40 a.m. the dietary manager (DM)-A was interviewed and stated R51 was not identified for weight loss, and no interventions	F 325	Changes to Prevent Recurrence Per the Weight Loss Policy and Procedure, all residents will be weighed upon admission to determine baseline and will be weighed weekly for the first month and at least once monthly thereafter (unless determined to be at high risk); all resident weights will be reviewed at the weekly high risk nutrition committee meeting. Residents who have realized a =>5% weight gain/loss in the previous 30 days or 10% in the previous 6 months will be identified, intakes reviewed, and a plan developed. All interventions will be discussed with the resident/representative and added to the residents plan of care. Each resident will be monitored weekly by the committee to determine success of interventions; this will continue until the committee determines the resident's intake meets or exceeds the resident's nutritional needs and resident is no longer in the high risk group. MONITORING The Director of Nursing (or designee) will review resident will review 2 care plans weekly to determine if all nutritional interventions are documented and are being followed; this includes monitoring to ensure that residents identified to be a nutritional risk are being followed per the Weight Loss Policy and Procedure. These audits will continue until the second quarter quality assurance committee meeting at which time the committee will determine if the audits will be increased, decreased, or discontinued.	

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F 325	Continued From page 40 had been put in place to address the weight loss. A policy and procedure on weight loss was requested, but not provided.	F 325		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 334		3/17/17

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F 334	Continued From page 41 refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer recommended pneumococcal vaccinations for 3 of 5 residents (R47, R16, R49) reviewed for immunizations.	F 334	Cornerstone Villa strives to ensure that all residents are offered and receive all recommended vaccinations. CORRECTIVE ACTION	

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F 334	Continued From page 42 Findings include: R47's quarterly Minimum Data Set (MDS) dated 11/6/16, indicated R47 was admitted on 12/16/13. On 1/9/14, R47 received pneumococcal polysaccharide (PPSV23) vaccination. R47 should have offered the pneumococcal conjugate (PCV13) one year later on 1/9/15. R16's quarterly MDS dated 10/31/16, indicated R16 was admitted on 12/8/15. On 10/2/13, R16 received the PPSV23 vaccination. On admission R16 should have offered the PCV13. R49's quarterly MDS dated 1/10/17, indicated R49 was admitted on 7/10/14. On 10/27/09, R49 received pneumococcal polysaccharide (PPSV23) vaccination. On admission R47 should have offered the pneumococcal conjugate (PCV13). On 02/02/17, at 9:16 a.m. DON verified R47, R16, and R49 did not received pneumococcal vaccinations. The DON stated she had gotten immunizations recommendation from pharmacy and did not address issue of not giving pneumococcal vaccines. The DON further stated she had no system in place for giving or tracking immunizations, and added, "I need to have better system in place for infection control, and follow up." All residents assessed for pneumococcal vaccinations as above were over the age of 65. CDC recommendations for pneumococcal vaccines include: one dose of PCV13 (also called Prevnar 13) is recommended for all adults aged	F 334	R47, R16 and R49 all have received their PCV13 required immunizations per the Influenza and Pneumococcal Policy and Procedure. CORRECTIVE ACTION AS IT PERTAINS TO OTHERS The Influenza and Pneumococcal Policy and Procedure was reviewed, updated, and communicated to licensed nursing staff at the inserviced on 2/9/17. On March 1st each department supervisor and key nursing staff attended the ICAR system training. A system for tracking immunizations has been developed and implemented and all current resident have been offered the recommended Pneumococcal vaccination on or before 3/2/2017 as well educated on the risks and benefits of the immunizations. All residents requesting updated immunizations received them on or before 3/2/2017; residents declining immunizations were educated on or before 3/2/2017. All resident immunization records will be reviewed to ensure that all immunizations have been offered, residents/representatives have been educated, risks and benefits disclosed. All residents (Rrepresentative) who have consented to the immunizations will received the immunizations per the policy and procedure. A flow sheet for documenting the resident name, type of education, risk/benefit disclosure, and decision has been developed and implemented. Those residents receiving	

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F 334	Continued From page 43 65 or older who've not previously received the vaccine. A dose of PPSV23 (also called Pneumovax 23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23. The facility Pneumococcal Vaccination-Resident/Patient policy dated 7/14, directed all adults aged 65 or older who have not previously received pneumococcal vaccine should receive a single dose of PCV13 followed by a dose of PPSV23, 12 months after the PCV13 vaccination was administered. The policy further directed all residents who previously received PPSV23 at age 65 or older should receive PCV13 one year or more after the PPSV23 dose was administered. The policy directed further all residents who previously received one or more PPSV23 vaccinations prior to age 65 who are now aged 65 or older should receive PCV13 one year or more after receipt of the most recent PPSV23 dose.	F 334	the immunizations will have the type and date of immunization documented and the date and type all future immunizations will be documented. This documentation will also be added into the resident medical record. All resident education and immunizations were completed on 3/2/2017. CHANGES TO PREVENT RECURRENCE Per the revised Influenza and Pneumococcal Policy and Procedure, all newly admitted residents will be assessed for pneumococcal vaccinations. If vaccinations have not been previously received, each resident will be offer the immunization at the time of admission, the resident/representative will be educated on the risks and the benefits of such immunizations. Those residents choosing to receive the immunizations will receive them. All future steps will be documented in the resident medical record as well as on the immunization tracking form. Immunization records will be reviewed during each quarterly/annual review to ensure that follow-up steps are identified and administered timely. MONITORING The Director of Nursing will audit 2 newly admitted residents per week and 2 quarterly/annual reviews to ensure that pneumococcal immunizations are up to date and/or that the immunizations have been offered, resident and/or representative have received immunization education, risks and	

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F 334	Continued From page 44	F 334	benefits have been clearly communicated, and that the resident and/or representative have either accepted or declined the immunizations. If accept, that the immunization was administered and properly documented in both the medical record and on the newly developed tracking forms. These audits will continue until the second quarterly quality assurance committee meeting at which time the committee will determine if the audits will be increase, decreased, or discontinued.	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	F 356		3/17/17

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F 356	Continued From page 45 (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the nurse staff posting included the actual hours worked. This had the potential to affect all 36 residents residing in the facility. Findings include: On 1/30/17, at 9:30 a.m. the Nurse Staff posting located on a bulletin board near the entrance to the facility lacked the actual hours worked by licensed and registered nursing staff. The nurse staff posting lacked the actual hours worked by	F 356	Cornerstone Villa strives to ensure that residents and family have access to accurate daily staffing information. CORRECTION The Nursing Staff Hours policy and procedure was reviewed and updated on 2/3/2017. A revised staffing form developed to ensure that required staffing and census information is posted in a prominent place readily accessible to residents and visitors. Staff were inserviced on this policy and procedure on	

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	245612	A. BUILDING _____ B. WING _____	02/02/2017

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F 356	Continued From page 46 licence and registered nursing staff throughout the survey from 1/30/17, through 2/2/17. On 2/2/17, at 2:35 p.m. the social work designee (SWD)-A verified she and the administrator post the nurse staff posting and that it did not have the actual hours worked on the posting. The hours were written on the nurse staff posting for the week during the survey, after the surveyor discussed it and verified the actual hours worked were not on the posting. The undated facility policy and procedure Nursing Staffing Hours Posting directed the report would reflect the number of direct care staff and their hours by shift, and would be hung on the bulletin board in the front lobby area.	F 356	2/09/2017. CHANGES TO PREVENT RECURRENCE The Administrator will audit 3 times weekly to ensure that the Nursing Staff Hours are posted timely and accurately per the revised policy and procedure. MONITORING The Administrator (or designee) will audit 3 time weekly to ensure that the Nursing Staff Hours are accurately posted daily for each shift per the revised policy and procedure. These audits will be continued until the second quarter quality assurance committee meeting at which time the committee will determine if the audits will be increased, reduced, or discontinued.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		3/17/17

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F 431	Continued From page 47 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate labels with directions for use were on medications	F 431	Cornerstone Villa Strives to ensure that all pharmaceutical products are labeled, stored, dispensed, and removed per the	

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F 431	Continued From page 48 for 2 of 25 (R50, R1) medications observed during medication administration. In addition, the facility failed to ensure expired influenza vaccines were removed from 1 of 3 medication refrigerators. Findings include: R50's physician orders dated 6/16/16, directed Norco 5-325 milligrams to be changed from as needed for pain to scheduled twice daily. On 2/1/17, at 7:08 a.m. during observation of medication administration R50's Norco (controlled pain medication containing hydrocodone and acetaminophen) pharmacy label had the wrong directions for use. On 2/1/17, at 1:14 p.m. registered nurse (RN)-A put a "refer to chart" sticker on R50's Norco medication card. RN-A verified R50's directions for use of the Norco was changed on 6/16/16, and stated if there is a change in directions, they fax the pharmacy and would call the pharmacy. RN-A stated when there is a change in a controlled medication, such as Norco, the pharmacy contacts the doctor and obtains the written scripts. RN-A stated she did not know if the pharmacy had been notified of the change. RN-A verified when there is a change the nurse should place a "refer to chart" sticker on the medication card. R1's physician orders dated 1/12/17, indicated R1's Lantus insulin was increased to 80 units from 60 units daily, and the Novolog insulin was decreased to 15 units twice daily from four times daily.	F 431	facility policy. CORRECTIVE ACTION A "refer to Chart" sticker has been placed on the medication card of R50's Norco and R1's Lantus and Novolog. The two unopened boxes of Afluria influenza vaccine were removed from the Birch unit refrigerator. CORRECTIVE ACTION AS IT PERTAINS TO OTHERS The Policy and Procedure for Labeling of Medication Containers has been reviewed and updated to include directions for medication direction changes. On 2/9/2017 the Licensed Nursing Staff were inserviced on the revised Labeling of Medication Containers policy and procedure. All resident medication cards have been checked to ensure that the labels on the medications match the card. This was completed on 2/24/2017. On 2/9/2017 Licensed Nursing staff were inserviced on Thrifty White Services Policy for disposal of expired medications. All medication carts and unit med room refrigerators have been checked for expired medications. This was completed on 2/3/2017. CHANGES TO PREVENT RECURRENCE All licensed nursing staff have been re-trained on both the policy and procedure for Labeling of Medication Containers and Destruction of Expired Medications. All medication direction	

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F 431	Continued From page 49 On 2/1/17, at 9:07 a.m. during observation of medication administration R1's Lantus (long-acting insulin) and Novolog (short-acting insulin) had pharmacy labels with the wrong directions for use. The licensed practical nurse (LPN)-B put a "refer to chart" sticker on the insulin. On 2/1/17, at 1:22 p.m. the consultant pharmacist verified staff should be putting a "refer to chart" sticker on the medication card when directions for use change. On 2/1/17 at 1:43 p.m. RN-A verified the R50 had received a lot of doses of Norco with the wrong label. On 2/2/17, at 2:27 p.m. the director of nursing (DON) stated nurses follow the electronic medication administration record (eMAR) for the current directions for medications. DON verified a "refer to chart" sticker should be placed on the medication cards when there was a change in directions. The DON further verified nurses should look at the label and compare it to the directions on the eMAR. Staff should get a new label from the pharmacy. The facility policy and procedure for Labeling of Medication Containers revised 4/07, directed each single unit dose package would include directions for use, and an improperly labeled medications would be returned to the issuing pharmacy. The policy and procedure lacked directions for a change in directions.	F 431	changes will be documented on a flow sheet as they are ordered. The night shift nurse will verify that a "refer to chart" label has been placed on the medication card for each direction change. The night shift nurse will audit each refrigerator daily to ensure that all expired medications are removed and will document these daily checks on a flow sheet. Monitoring The Director of Nursing (or designee) will audit medication direction changes weekly to determine that the change has been properly marked on the medication card and that notifications have been made per the policy and procedure. The Director of Nursing (or designee) will audit each medication room refrigerator and/or medication cart 2 times weekly to ensure the flow sheets have been completed properly and that there are no expired medications in any of the refrigerators or medication carts. These audits will continue until the second quarterly quality assurance committee meeting at which time the committee will determine if these audit will increase, decrease, or be discontinued.	

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F 431	Continued From page 50 On 1/31/17, at 5:34 p.m. the medication refrigerator on the Birch unit was observed to have two unopened boxes of Afluria 2015-2016 formula influenza vaccine that expired on 6/5/16. The DON confirmed this finding. On 1/31/17, at 6:26 p.m. the DON stated licensed nurses on the overnight shift check for expired medication. The DON stated that the facility usually offers influenza vaccinations to residents and staff during November and December. The DON stated residents admitted to the facility during flu season (October through March) are offered vaccinations. A Thrifty White Pharmacy Services policy provided by the facility revised April 2014, indicated that outdated medications are to be immediately removed from stock.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		3/17/17

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F 441	Continued From page 51 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 52 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive infection control program was developed and utilized to include identification of organisms causing infections, tracking and trending, identification of appropriate and effectiveness of treatments. This had the potential to affect all 36 residents residing in the facility. Finding included: On 1/26/17, at 9:30 a.m. the infection control program was reviewed with the director of nursing (DON), who was the infection control specialist. The DON was responsible for maintaining the infection control log. The DON stated the logs were reviewed at the interdisciplinary team (IDT) meeting and discussed quarterly in quality assurance (QA) meeting. The logs were looked at to determine the infection rate, new antibiotics ordered, and reviewed with medical director. The facility monthly infection control logs were reviewed from May 2016, through January 2017. The columns listed residents names, room numbers, diagnosis, antibiotic, and if hospital acquired. The infection control log lacked date of onset, signs and symptoms, diagnoses,	F 441	Cornerstone Villa strives to ensure that an effective infection prevention and control program is in place and being effectively monitored. CORRECTION On March 1st an ICAR System Representative provided infection control training for the Nursing, Dietary, and Environmental Service departments regarding effective infection prevention and effective monitoring/tracking systems. CORRECTION AS IT PERTAINS TO OTHERS With the assistance and guidance of the ICAR System Representative, the facility has developed and implemented an effective infection control tracking/trending system per ICAR recommendations. A quality assurance sub-committee of interdisciplinary staff has been convened and will review and discuss monthly the tracking and trending of both resident and staff infections. Recommendations of this sub-committee will be discussed at each quarterly quality assurance committee meetings.	

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F 441	Continued From page 53 identification of organisms, antibiotic effectiveness, and date resolved. On 02/01/2017, at 2:14 p.m. the infection control program was reviewed again with the DON. The DON verified the infection control log lacked information to identify infections needed for tracking data and trends of infectious diseases. The facility Infection Control Program dated 2009, directed staff to investigate, control, and record infections to prevent the spread of infections.	F 441	CHANGES TO PREVENT RECURRENCE All ICAR system recommendations will be reviewed by both the quality assurance sub-committee and committee. Key departmental staff will receive ongoing infection control training as well as policy and procedure updates from the ICAR system representative. CHANGES TO PREVENT RECURRENCE The Director of Nursing and/or designee will participate in future training recommended by the ICAR Representative to ensure that the facility Infection Control Policy and Procedure stay up-to-date. The revised infection tracking/trending logs will be presented and discussed at all quarterly quality assurance committee meetings and monthly at the QA sub-committee meeting. MONITORING The Administrator (or designee) will review the revised infection tracking/trending logs weekly to ensure that all recommended information is being documented per the ICAR recommendations. These audits will continue until the second quarterly quality assurance committee meeting at which time the committee will determine if the audits will be increased, decreased, or discontinued.	

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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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/03/2017

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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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or 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 40 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		

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K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 (11), states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could	K 324	CORRECTION Environmental Services Director contacted JN Johnson, whom provides the facility fire system semi-annual inspections, on 2/1/2017 to report the failure to provide the required annual inspection during the month of September 2016. While the January of 2017 inspection was completed, JN Johnson's schedule did not include the September inspection. JN Johnson has corrected	3/3/17

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K 324	Continued From page 3 affect residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 11:00 a.m. to 2:00 p.m. on 02/01/2017, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by a Maintenance Supervisor.	K 324	their scheduling system problem per their letter to Cornerstone Villa on 2/2/2017. The Environmental Services Director placed a reminder in his system on 2/2/2017 to ensure that all semi-annual inspections are complete timely.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was	K 372	Correction not needed - Cornerstone Villa	3/3/17

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 _____	**02/01/2017**

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

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K 372	Continued From page 4 determined that the facility failed to maintain smoke barrier walls in accordance with NFPA Life Safety Code 101 (12), Sections 18.3.7 and 18.3.7.3. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect all 40 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 2:00 p.m. on 02/01/2017, 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. This deficient condition was verified by a Maintenance Supervisor.	K 372	has achieved a passing FSES score: see attached FSES/HC	
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		3/3/17

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 _____	**02/01/2017**

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

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K 923	Continued From page 5 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (12) section 5.1.3.3.4.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 2:00 p.m. on 02/01/2017, observations revealed that there	K 923	The Environmental Services Director removed the electric carpet sweeper from the facility oxygen storage room on 2/1/2017. Signage was posted in the oxygen storage room on 2/2/2017 communicating that storage of any/all battery powered electrical motor driven power equipment was prohibited from being placed/stored in the oxygen storage room. Inspection of the oxygen room for storage of prohibited equipment has been added to the environment services monthly	

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	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**02/01/2017**

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

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K 923	Continued From page 6 are battery powered electrical motor driven power sweepers / carpet cleaners being stored next to the oxygen cylinders located in the oxygen storage room. This deficient condition was verified by a Maintenance Supervisor.	K 923	inspection list to ensure compliance. This was added to the list on 2/2/2017. These inspections are responsibility of the Environmental Services Director and are completed by either the Director or designee.	