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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LJZQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00974

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

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

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

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

6. DATE OF SURVEY **09/08/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, HFE NEII 09/16/2014 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS
Posted 11/10/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
09/03/2014 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245307

November 9, 2014

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

Dear Ms. Swanson:

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

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

Effective August 26, 2014 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 16, 2014

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

RE: Project Number S5307024

Dear Ms. Swanson:

On July 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 3, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 26, 2014 and therefore remedies outlined in our letter to you dated July 31, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing	9/8/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **08/15/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/26/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/26/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/26/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/26/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	09/16/2014	28035	09/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/17/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245307	A. Building B. Wing **01 - MAIN BUILDING**	9/3/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/04/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0046		LSC K0050	
ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/06/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0051		LSC K0052		LSC K0054	
ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0056		LSC K0062		LSC K0067	
ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0130		LSC K0144		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	09/16/2014	27200	09/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/16/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LJZQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00974

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

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

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

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

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

6. DATE OF SURVEY **07/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NEII 08/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN:24-5307

On July 17, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. In addition, investigations of complaint numbers: H5307008, H53007009 were conducted and found to be unsubtantiated. Refer to the CMS 2567 (for both health and life safety code) along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 31, 2014

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

RE: Project Number S5307024, H5307008, H53007009

Dear Ms. Swanson:

On July 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 17, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5307008, H53007009.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 17, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5307008, H53007009 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 26, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 26, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 17, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new

admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

eel 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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5307s14hlth&ohfc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

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F 000	INITIAL COMMENTS A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. An investigation of complaint H5307008 and H5307009 were completed. The complaints were not substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 242	Cornerstone Nursing and Rehab Center	8/26/14

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

Electronically Signed | 08/07/2014

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F 242	Continued From page 1 facility failed to ensure resident bathing preferences were accommodated for 1 of 3 residents (R47) reviewed for choices in daily routine. Findings include: R47's quarterly Minimum Data Set (MDS) dated 6/1/14, indicated R47 had intact cognition and required staff physical assistance for bathing. R47's care plan dated June 2014, indicated R47 required one staff assistance with bathing but did not address bathing frequency. The weekly Bath Schedule indicated R47 received one bath per week. On 7/14/14, at 12:40 p.m. R47 indicated he would like to receive a bath more than once a week but stated "they don't have the help." He further stated that he was scheduled for two baths per week the previous month but "they couldn't carry it out." On 7/17/14, at 10:21 a.m. nursing assistant (NA)-I stated the regular bath aid, who was on vacation, was the person who figured out the bath schedule based on the residents' needs or requests. NA-I stated she thought the nurses assessed for which residents required more than one weekly bath. On 7/17/14, at 10:28 a.m. registered nurse (RN)-A stated the RNs assessed residents needs for additional baths and also asked about their bathing preference upon admission. RN-A stated if the resident asked, they would be provided additional baths. RN-A stated the	F 242	strives to provide residents every opportunity to choose activities, schedules, and health care consistent with their interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of their life while in the facility that are important to the resident. R47 care plan was reviewed and updated to reflect his desire to have twice a week bathing. Resident preferences for bathing shall be asked upon admission and at each residents quarterly care conferences to ensure requests are being met. Nursing staff shall be educated regarding the updated care plan, change in bathing schedule, importance of fulfilling resident requests, and change in care conference practices. The DON or designee shall complete weekly random audits of residents bathing satisfaction for 2 weeks and quarterly thereafter to ensure compliance is maintained. Results of these audits shall be reviewed at the facility Quality Assurance Committee meetings to ensure compliance.	

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F 242	Continued From page 2 regular bath aid also asked the residents if the proposed plan was enough. On 7/17/14, at 10:28 a.m. NA-I stated R47 had asked for additional baths per week and received them when there was a spot available. On 7/17/14, at 10:31 a.m. R47 stated he received a bath on Wednesdays and had not received a second bath because the facility was short handed. R47 again stated he would like a bath more than once a week. On 7/17/14, at 2:32 p.m. RN-A confirmed she would have expected R47's request for additional baths be identified and honored. A policy regarding resident choices was requested but none was provided.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 2 of 3 residents (R36, R26) in the sample who were reviewed for activities.	F 248	Cornerstone Nursing and Rehab Center is committed to providing an ongoing program of activities designed to meet the activity needs of each resident in accordance with the comprehensive activities assessments based on physical,	8/15/14

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F 248	Continued From page 3 Findings include: R36 was not provided activity as directed by the care plan. R36's annual Minimum Data Set (MDS) dated 4/27/14, indicated R36 was diagnosed with a stroke and dementia, had severe cognitive impairment and required extensive staff assistance with bed mobility, transfers and locomotion. The MDS also indicated R36's activity preferences included listening to music, doing things with groups of people, participating in favorite activities and spending time outdoors. R36 required extensive assistance with bed mobility, transfers, and locomotion. R36' Activity Care Area Assessment (CAA) dated 4/30/14, indicated R36 had little interest or pleasure in doing things, had dementia, was at risk for social isolation, missed activities, had depression, low self esteem, had good family support with family visiting often, liked music programs, TV and people watching in the the lobby. The CAA further indicated staff would continue to provide 1:1 support and encouragement throughout the day. R36's care plan dated 5/7/14, indicated R36 would be encouraged and invited to attend activities daily and R36 would attend activities of interest. The interventions included 1:1 activities two times per week.	F 248	mental, and psychological well-being of the resident. Residents 26 and 36 comprehensive activity assessments/observation reports and care plans have been reviewed and updated on August 5, 2014 to meet the activity needs. Resident activity care plans shall be reviewed weekly at care conference to ensure they accurately reflects the residents current individual needs based on the comprehensive assessment/observation. The Activity Director is responsible for ensuring appropriate, timely completion of each residents assessments/observation reports. The daily 1:1 log has been reviewed to reflect those residents receiving 1:1 and the frequency according to each residents plan of care. The Quality Assurance Committee shall complete random audits to ensure compliance is maintained.	

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F 248	Continued From page 4 R36's computerized Activity Assessment dated 5/17/13, noted several incomplete questions. The activity director (AD) who completed the assessment verified the assessment was not complete. On 7/14/14, during continuous observation from 7:00 a.m. until 2:45 p.m. R36 was not observed to receive any activity intervention. However, on 7/15/14, at 5:20 p.m. R36 was observed at the supper table, gagging. Family stated yesterday, R36 had nausea and vomiting. Observations on 7/16/14, revealed R36 continued to be ill. R36's One To One Visit documentation revealed the following: -March 2014, out of eight opportunities received two times. -April 2014, out of eight opportunities received zero times. -May 2014, out of eight opportunities received four times. -June 2014, out of eight opportunities received two times. On 7/17/14, at 10:12 a.m. the AD stated R36 had good days and bad days. The AD stated R36 did not get involved in activities and would watch from a distance. The AD stated the other activity employee had resigned in March, and since then she was by herself to provide all the resident activities. The AD stated a new activity employee was recently hired, and would work three days a week depending on her schedule. The AD added,	F 248		

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F 248	Continued From page 5 we try to do 1:1 activities a couple times a week with R36, however confirmed the frequency was lacking and stated "I just can't get to everybody." In addition, the AD stated R36 received daily family visits and she was so thankful for that. Lastly, the AD verified R36's activity care plan was not followed related to 1:1 activities two times a week. R26 was not provided activity as directed by the care plan. R26's quarterly MDS dated 6/29/14, indicated R26 was diagnosed with Alzheimer's disease and osteoporosis. The MDS also indicated R26 had severe cognitive impairment and required total assistance for bed mobility, transfers and was non ambulatory. R26's Activity CAA dated 5/11/14, indicated R26 had little interest or pleasure in doing things and did not participate in "favorite" activities. The assessment indicated R26 had advanced dementia, slept most of the day, rarely verbalized and when she did speak only said one or two word phrases. The assessment indicated the activity department was to offer R26 1:1 activities twice a week and were to include weekly story reading and applying lotion to hands while visiting with her. The assessment also indicated R26 enjoyed holding stuffed animals or a toy doll. The assessment indicated staff were to support and encourage R26 throughout the day in an attempt to preserve her dignity and psychosocial well being.	F 248		

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F 248	Continued From page 6 R26's Activity Assessment dated 5/15/14, indicated R26 had a religious preference yet did not actively participate and had no past or current interests. The Focus of programming portion of the assessment read "Resident will be given 1:1's 2 x a week. Will see how well this is received." R26's care plan dated 7/9/14, directed staff to assist R26 with 1:1 activities two times a week On 7/15/14, at 3:00 p.m. the July 2014, activity calendar indicated there would be a "coffee and Co" activity. At the time of the activity, R26 was observed seated in the lobby area and was not observed to be offered or assisted to join the coffee time activity occurring in the dining room. At 6:00 p.m. the calendar indicated "Game Night." R26 was observed to remain in the lobby area while other resident's played Bingo. At no time was R26 offered or assisted to join the activity. On 7/16/14, at 9:00 a.m. the activity calendar indicated "Bible Study." At 9:15 a.m. R26 was observed seated in the lobby area while a volunteer lead a group of residents in Bible Study in the activity room. On 7/17/14, from 9-11 the activity calendar indicated "Beauty Day." R26 was observed seated in the lobby area and was not offered or assisted with "Beauty Day" activities.	F 248		

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F 248	Continued From page 7 R26's One to One Visit documentation revealed the following: - March 2014, out of eight opportunities, R26 received two visits. - April 2014, out of eight opportunities, R26 received no visits. - May 2014, out of eight opportunities, R26 received one visit. - June 2014, out of eight opportunities, R26 received two visits. - July 2014, out of four opportunities R26 received one visit. On 7/17/14, at 10:45 a.m. the AD confirmed R26 was to receive two 1:1 visits a week. She stated the activity department was short staffed and she had not had enough time to ensure R26 had received the 1:1 visits. She stated since R26 had advanced dementia, she was not able to respond to questions about her past and she could not be assessed as to what type of activities she had liked in the past. She stated she had not contacted R26's family members to determine what past interests R26 had liked so she was not sure what type of hobbies/interests R26 had enjoyed prior to entering the facility. The AD stated she attempted to read stories or reminisce with R26 but she did not respond well. She stated she could contact the family members again to determine what type of activities R26 may enjoy. She confirmed R26 had not received the 1:1 visits as directed by the care plan. An activity policy was requested and the AD stated there was none.	F 248		

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F 282	Continued From page 8	F 282		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the care plan for 6 of 6 residents (R5, R7, R24, R26, R10, R14,) reviewed for incontinence, for 4 of 5 residents (R26, R10, R14, R24,) who required assistance with repositioning, for 2 of 3 residents (R26, R36) who were identified to require an individual activity program and for 1 of 1 resident (R13) who required assistance with eating. Findings include: Incontinence care R5 did not receive assistance with toileting as directed by the care plan. R5's care plan dated April 2014, directed staff to assist with toileting every 2 hours. On 7/15/13, at 3:22 p.m. R5 was observed seated in her wheelchair in the dining room. - At 5:00 p.m. two staff members were observed to transfer R5 from the wheelchair to a standard dining room chair. -At 5:35 p.m. R5 was observed to eat her evening	F 282	Cornerstone Nursing and Rehab Center strives to provide and arrange for services provided by qualified persons in accordance with each resident□s written plan of care. R13□s care plan was reviewed and updated to reflect new interventions that will ensure resident receives the assistance she needs for ADL□s. Staff education and revisions have been made to assure that this is being accomplished. R13□s care plan was reviewed and updated on 8/6/14 to increase resident to full staff assistance during meal and snack times. R10, R14, R24, and R26, care plans were reviewed for repositioning schedules on 8/7/14 and were current. R5, R7, R10, R14, R24, and R26, care plans were reviewed for incontinence schedule on 8/7/14 and were current. On August 5, 2014, the activity care plan for resident 26 and 36 was reviewed to meet the individual activity needs and was current. Facility policies and procedures and documentation systems were reviewed on 8/7/14, and updates made as necessary. Nursing staff shall be educated on changes to care plans and the importance of following	8/26/14

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F 282	Continued From page 9 meal. -At 6:05 p.m. staff were observed to transfer R5 back into the wheelchair and proceeded to wheel her into the lobby area. R5 was observed to remain in the lobby until 7:30 p.m. at which time nursing assistant (NA)-B transferred R5 to the toilet via a standing lift. R5 was observed to be incontinent of urine. At 7:32 p.m. NA-B stated she had not assisted R5 with toileting since arriving at the facility at 2:30 p.m. She confirmed R5 had not received assistance with incontinence cares for five hours. On 7/16/14, at 12:35 p.m. licensed practical nurse (LPN)-B stated R5 was to receive assistance with incontinence cares every two hours as directed by the plan of care. On 7/17/13. at 9:40 a.m. registered nurse (RN)-A stated R5 was to receive assistance with incontinence cares every two hours. R7 did not receive assistance with toileting as directed by the care plan. R7's Care Plan dated May 2014, indicated R7 was frequently incontinent of bowel and bladder and required assist of one with toileting. The care plan directed staff to empty urinal as directed and encourage toileting schedule every 2 hours and as needed or requested by R7. On 7/16/14, from 7:34 a.m. until 10:41 a.m., R7 was continuously observed. -At 7:34 a.m. NA-A and NA-E were observed exiting R7's room. R7 was observed seated in a wheelchair in front of an over bed table	F 282	care plans. Residents care plans shall be review at weekly care conferences to ensure they are current and meet the residents needs according to the plan of care. The signature of the Activity Director and/or Care Conference RN shall be verification of care plan compliance. The Quality Assurance Committee shall complete random audits to ensure compliance.	

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F 282	Continued From page 10	F 282		

independently eating breakfast.
-At 9:06 a.m. NA-C was observed to remove R7's breakfast tray from R7's room. R7 was observed to remain seated in the wheelchair watching television.
-At 10:00 a.m. NA-D was observed to enter R7's room briefly and exit.
-At 10:41 a.m. NA-A stated she didn't usually work with R7 and she wasn't sure how often he should be checked but stated he wore a brief and she thought he was sometimes incontinent. NA-A then asked R7 if he needed the bathroom. R7 refused and NA-A left the room without checking for incontinence.

At 10:43 a.m. NA-C confirmed R7 was incontinent and wore a brief. She stated he was to be checked every 2 hours. NA-C stated she had not checked R7 for incontinence since he got up that morning. NA-C entered R7's room to assist him to dress.

At 10:57 a.m. NA-C stated R7's incontinent brief was wet when she went in to assist him to dress. She stated there were no skin concerns and if there were she would contact the nurse.

At 11:00 a.m. NA-D stated she had offered R7 a bath at 10:00 a.m. which he refused. She stated she did not do anything else for R7 and he did not request anything. NA-D stated she did not check, change or offer R7 the toilet when she offered him his bath.

On 7/17/14, at 2:17 p.m. RN-A confirmed R7 should have been checked for incontinence and changed or offered the toilet every 2 hours as directed by the care plan.

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F 282	Continued From page 11 R24 did not receive incontinence care according to the care plan. R24's care plan dated 4/22/14, read assist of 1 to 2 staff to check and change every 2 hours and as needed. On 7/16/14, at 6:25 a.m. R24 was observed in the lobby seated in a wheelchair. -At 6:40 a.m. R24 was observed to receive therapy in the rehab room. -At 6:52 a.m. NA-E returned R24 to the lobby. R24 was continuously observed until 7:40 a.m. -At 7:40 a.m. NA-E assisted R24 to the dining room. R24 was continuously observed until 8:50 a.m. -At 8:50 a.m. NA-E assisted R24 from the dining room to Bible study. R24 was continuously observed until 9:30 a.m. -At 9:30 a.m. NA-H stated she realized R24 was behind on her toileting schedule. However, R24 was positioned in the Bible study so far into the group that NA-H could not remove her. NA-H stated she did not know that NA-E had brought R24 directly from the dining room to Bible study. NA-H stated R24 was placed in the wheelchair at 6:30 a.m. and had her brief changed at 6:20 a.m. NA-H stated R24 was to have her brief checked and changed every 2 hours. -At 9:35 a.m. NA-H went to find another staff to assist her with the transfer. -At 9:45 a.m. R24 NA-H and the physical therapy assistant were observed to transfer R24 to bed with the mechanical lift. -At 9:46 a.m. NA-H stated R24 was incontinent of urine and needed to be changed. A clean brief was applied. NA-H confirmed R24 was not provided incontinence care for 3 hours and 26	F 282		

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F 282	Continued From page 12 minutes. At 12:19 a.m. RN-A stated R24 was to be checked and changed every 2 hours. At 12:37 p.m. RN-A stated the NAs had a list of residents and were to write down when the resident last received cares. RN-A stated R24's care plan was not followed for incontinence care. TOILETING AND REPOSITIONING R26 did not receive assistance with incontinence cares and repositioning on the evening of 7/15/14, for 4 hours and 10 minutes. R26's care plan dated 7/9/14, directed staff to assist R26 with incontinence cares and repositioning every two hours. On 7/15/14, at 3:22 p.m. R26 was observed in the lobby seated in a wheelchair. - At 4:57 p.m. R26 was wheeled into the dining room for the evening meal. - At 6:05 p.m. R26 was wheeled out of the dining room and into the lobby. - At 7:35 p.m. NA-J stated she had just assisted R26 into bed. NA-J stated R26 did not have any red or open areas and confirmed R6 was incontinent of urine. She stated R26 was last assisted with repositioning at 3:20 p.m. a total of four hours and 10 minutes earlier. On 7/17/13, at 9:40 a.m. RN-A stated the nursing assistants were to monitor the residents every two hours and were to communicate between shifts to ensure all residents received timely assistance with incontinence cares and	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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F 282	Continued From page 13 repositioning. R10 did not receive timely assistance with incontinence care and repositioning on the evening of 7/16/14, and the morning of 7/17/14. R10's care plan dated 7/2014, directed staff to assist R10 with incontinence cares and repositioning every two hours while in the wheelchair. On 7/15/14, at 3:20 p.m. R10 was observed to be assisted from bed into a wheelchair via a mechanical lift and then assisted to the dining room for a snack. -At 3:30 p.m. R10 was wheeled to the lobby area and remained there until 4:45 p.m. at which time she was assisted to the dining room for the evening meal. -At 6:00 p.m. R10 was observed wheeled from the dining room to the lobby area and remained there until 6:47 p.m. at which time NA-J wheeled R10 to her room for evening cares. -At 7:05 p.m. NA-B and NA-J were observed to transfer R10 from the wheelchair into bed. R10 was observed to be incontinent of urine. -At 7:16 p.m. NA-B confirmed R10 was last assisted with incontinence cares and repositioning at 3:20 p.m. a total of three hours and 45 minutes earlier. On 7/16/14, at 6:40 a.m. R10 was observed in the lobby seated in a wheelchair. -At 7:13 a.m. R10 was observed to be assisted into the dining room for breakfast. -At 8:53 a.m. R10 was observed to be assisted from the dining room to the Bible Study activity in	F 282		

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F 282	Continued From page 14 the day room. -At 9:48 a.m. R10 was wheeled from the activity to the lobby area. -At 9:49 a.m. R10 was observed to be wheeled from the lobby area to her room. -At 9:52 a.m. staff were observed to transfer R10 from the wheelchair into bed via a mechanical lift. R10 was observed to be incontinent of urine. Her skin was pink and intact. -At 10:10 a.m. NA-C stated R10 had not received assistance with incontinence cares or repositioning since 6:00 a.m. a total of three hours earlier. On 7/17/14, at 9:40 a.m. RN-A stated R10 was to receive assistance with incontinence and repositioning every two hours as directed by the plan of care. R14 did not receive assistance with incontinence care or repositioning as directed by the care plan. R14's Care Plan dated 5/22/14, indicated R14 wore an incontinent brief at all times, required the assist of two staff to check and change incontinent brief every two hours and as needed The Care Plan also indicated R14 required assistance of two staff to turn and reposition every two hours while in bed and directed staff to offload (reduce pressure) R14 every two hours and as needed when in a chair. On 7/15/14, at 4:39 p.m. NA-G was observed to enter R14's room and turn off his call light, followed by NA-F who entered the room with a mechanical lift. -At 5:05 p.m. R14 was observed in the dining room seated in his wheelchair.	F 282		

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F 282	Continued From page 15 -At 5:58 p.m. R14 was observed seated in his wheelchair in the lounge area. R14 was observed tilted all the way back in his tilt in space wheelchair. He remained in the lounge area until after 7:20 p.m. At 7:20 p.m. R14 stated he had been up in his wheelchair since before supper. He stated it did get difficult sitting up in the chair at times. R14 indicated he usually sat up in the chair until he went to bed at about 8:00 p.m. At 7:26 p.m. NA-F stated R14 had been up in his chair since before supper. She stated he got up at 4:50 p.m. At 7:29 p.m. NA-F was observed getting R14 ready for bed. At 7:31 p.m. NA-F left R14's room to get assistance. At 7:44 p.m. NA-F and NA-G returned to the room to complete evening cares. At 7:47 p.m. NA-G and NA-F were observed to assist R14 into bed via a mechanical lift and incontinence cares were provided. R14's incontinence brief was saturated with urine. R14's left buttock was observed to have an open area measuring approximately 1.0 cm in diameter surrounded by a reddened area of approximately 3.0 cm. R14's right buttock revealed a 1.0 cm reddened area without any open area observed. At 8:00 p.m. LPN-D confirmed R14 should have been repositioned and toileted every 2 hours. LPN-D also stated R14 was to be repositioned every two hours due to having problems with his pressure ulcers opening up again. At 8:02 p.m. NA-G confirmed R14 was up in his	F 282		

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F 282	Continued From page 16 chair without repositioning or incontinence care from 4:50 until 7:47 p.m. NA-G confirmed R14 should have been repositioned and changed every two hours while in his chair and confirmed he should have been offloaded after being up for 2 hours. On 7/17/14, at 9:10 a.m. RN-B confirmed R14's care plan and stated R14 should have been repositioned / offloaded while in the wheelchair and provided incontinence care every 2 hours. R24 did not receive repositioning according to the care plan. R24's care plan dated 4/22/14, indicated assist of 2 to turn and reposition every 2 hours and as needed and to offload every 2 hours and as needed when in wheelchair. On 7/15/14, from 5:49 p.m. until 7:34 p.m. R24 was continuously observed. R24 was not repositioned until 7:34 p.m. -At 7:22 p.m. NA-G assisted R24 to her room. NA-G stated she and NA-F had placed R24 in the wheelchair at 4:00 p.m. NA-G stated normally R24 would be put to bed at 6:00 p.m. however, she was "running behind." NA-G verified R24 was to be repositioned every 2 hours. -At 7:34 p.m. (3 hours & 34 minutes later) NA-F and NA-G were observed to transfer R24 to bed via a mechanical lift. NA-F stated R24 did not always get repositioned every 2 hours because there were a lot of residents on the every 2 hour schedule and they were also trying to get call lights answered.	F 282		

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F 282	Continued From page 17 On 7/16/14, R24 was continuously observed from 6:25 a.m. until 9:45 a.m. During this time R24 was not observed to receive assistance with repositioning. At 9:45 a.m. NA-H and the physical therapy assistant were observed to assist R24 into bed via mechanical lift. (3 hours & 20 minutes) At 12:19 a.m. RN-A stated R24 was at risk for skin breakdown and was to be repositioned every 2 hours. At 12:37 p.m. RN-A stated "that's no good" when told about the long time frames R24 remained up in the wheelchair. RN-A stated R24's care plan was not followed for repositioning. ACTIVITIES R26 did not receive assistance with activities according to the plan of care. R26's care plan dated 7/9/14, directed staff to assist R26 with 1:1 activities two times a week. During the survey conducted on 7/14/14, from 6:45 a.m. to 2:00 p.m. On 7/15/14, from 12:30 p.m. to 8:00 p.m. on 7/16/14, from 6:30 a.m. .to 2:00 p.m. and on 7/17/14, from 8:00 a.m. to 12:00 p.m. R26 was observed to eat her meals in the dinning room, sit by herself in the lobby area or rest in bed. At no time was R26 observed to receive one to one visits or participate in any group activities. The One to One Visit documentation revealed	F 282		

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	245307	A. BUILDING _____ B. WING _____	07/17/2014

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F 282	Continued From page 18 the following information: - July 2014, out of four opportunities R26 received one visit. - June 2014, out of eight opportunities, R26 received two visits. - May 2014, out of eight opportunities, R26 received one visit. - April 2014, out of eight opportunities, R26 received no visits. - March 2014, out of eight opportunities, R26 received two visits. On 7/17/14, at 10:45 a.m. the activity director stated R26 was to receive two 1:1 visits a week and confirmed R26 had not received visits as directed by the plan of care. R36s did not receive 1:1 activities according to the care plan. R36's care plan dated 5/7/14, indicated R36 would be encouraged and invited to attend activities daily and would also attend activities of interest. The interventions included 1:1 activities two times per week. R36's One To One Visit documentation revealed the following: -June 2014, out of eight opportunities received two times. -May 2014, out of eight opportunities received four times. -April 2014, out of eight opportunities received zero times.	F 282		

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F 282	Continued From page 19 -March 2014, out of eight opportunities received two times. On 7/17/14, at 10:12 a.m. the activity director (AD) stated they tried to provide R36 1:1 activities a couple times a week and confirmed this had been lacking. The AD stated "I just can't get to everybody." The AD verified R36's care plan was not followed related to the provision of activities. ASSISTANCE WITH EATING: R13 did not receive assistance with eating according to the care plan. R13's care plan dated 5/7/14, indicated R13 was independent with drinking fluids and eating meals after set up. The care plan directed staff to assist R13 with eating as needed / tolerated in an attempt to increase intake. On 7/14/14, at 7:32 a.m. R13 was served scrambled eggs and toast. During continuous observation until 8:15 a.m. R13's breakfast remained in front of her and R13 did not receive assistance with eating the meal as needed. On 7/15/14, at approximately 5:21 p.m. R13 was served her evening meal. Two staff members were observed seated at her table assisting other residents. Until, 5:33 p.m. R13 was observed to attempt to feed herself often putting an empty spoon in her mouth without interventions or	F 282		

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F 282	Continued From page 20 cueing from the two staff members. At 5:33 p.m. the NA noted R13 had put an empty spoon in her mouth and asked R13 if she needed assistance in which R13 shook her head yes. On 7/16/14, from 8:05 a.m. through 8:22 a.m. R13 was observed attempting to eat her breakfast meal positioned approximately 12 inches away from the table and frequently put an empty spoon in her mouth in an attempt to feed herself. Staff were not observed to assist R13 with eating. At 12:58 p.m. RN-A confirmed R13's care plan and stated staff should have followed the care plan and assisted R13 with eating. RN-A verified the care plan was not followed. The Care Plan policy dated 10/17/13, directed staff to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing and psychological needs.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		8/26/14

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F 312	Continued From page 21 by: Based on observation, interview and document review, the facility failed to provide assistance with eating for 1 of 1 resident (R13) according to their assessed need. Findings include: R13's Activity of Daily Living Care Area Assessment (CAA) dated 11/17/13, indicated R13 had macular degeneration and required assistance with eating. R13's quarterly Minimum Data Set (MDS) dated 5/7/14, indicated R13 had moderate cognitive impairment and required extensive assistance with eating. R13's care plan dated 5/7/14, indicated R13 was independent with drinking fluids and eating meals after set up. The care plan directed staff to assist R13 with eating as needed / tolerated in an attempt to increase intake. On 7/14/14, at 7:32 a.m. R13 was observed in the dining room and served scrambled eggs and toast. R13 had a neck pillow on and her eyes were closed. -At 7:36 a.m. R13 had not started to eat her breakfast yet. -At 7:41 a.m. R13 had her eyes open and then shut again. R13's food remained in front of her, untouched. At this time nursing assistant (NA)-E was observed to move R13 up closer to the table, woke her up and told her what food was in front of her. R13 requested salt for her eggs. R13 was observed to use her left hand to eat and attempt	F 312	Cornerstone Nursing and Rehab Center strives to provide residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R13□s care plan was reviewed and updated on 8/6/14 to increase resident to full staff assistance during meal and snack times. Resident will continue to eat finger type foods and beverages independently as able. Occupational therapy shall evaluate and determine if further interventions are necessary in maintaining independence where possible. Dietary shall re-evaluate food options to maintain good nutrition. Staff shall be educated on the updated care plan and any changes/recommendations by dietary and therapy departments. The DON or designee shall complete daily random audits of all residents feeding needs and efficacy of R13□s change in care plan for 2 weeks and quarterly thereafter, as well as other residents. Audits shall be reviewed at the facility Quality Assurance Committee meetings for compliance.	

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F 312	Continued From page 22 to get the eggs on her spoon. R13 brought the spoon to her mouth twice with no food on it. She then brought the spoon to her mouth at least 3 more times with no food on it. -At 7:44 a.m. R13 continued to try and eat the scrambled eggs and continued to bring the empty spoon to her mouth. -At 7:45 a.m. R13 was observed to pick up a half of piece of toast, take a drink of apple juice, pick up the spoon and proceeded to move the scrambled eggs around on her plate. -At 7:46 a.m. R13 was observed to get a piece of egg into her mouth. R13 also took another bite of egg and also a bite of toast. -At 7:50 a.m. R13 brought the empty spoon to her mouth. -At 7:51 a.m. R13 took another bite of toast and a drink of water. -At 7:53 a.m. R13 had her eyes closed and was not eating. -At 7:55 a.m. NA-E asked R13 if she was going back to sleep. R13 stated "no." -At 7:57 a.m. R13 picked up her piece of toast. -At 8:03 a.m. R13 was unable to get the scrambled eggs onto her spoon. R13 brought the empty spoon to her mouth twice. -At 8:06 a.m. R13 continued to try and get the eggs onto her spoon unsuccessfully. -At 8:09 a.m. R13 got a bite of eggs onto the spoon. -At 8:15 a.m. NA-E asked R13 if she wanted anymore to eat. R13 shook her head no. On 7/15/14, at 5:02 p.m. R13 was observed to have a glass of water, juice and hot coffee in front of her at the dining room table. -At 5:23 p.m. R13 was observed to take a bite of buttered bread. She had hot dish and green	F 312		

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F 312	Continued From page 23 beans on her lipped plate. -At 5:24 p.m. R13 was was observed staring and not eating her food. Two NAs were observed seated at the same table assisting the table mates. The NAs did not encourage R13 to pick up her spoon to eat. -At 5:26 p.m. R13 was observed to take a bite of hot dish. -At 5:28 p.m. R13 took another bite of hot dish, -At 5:29 p.m. R13 put the empty spoon in her mouth twice, and was scraping the hot dish to the middle of her plate. -At 5:30 p.m. R13 was observed to put the empty spoon in her mouth again. -At 5:30 p.m. R13 unsuccessfully attempted to put hot dish on her spoon and put the empty spoon in her mouth. On the second attempt R13 got 2 noodles on the spoon. -At 5:31 p.m. NA-G sat down next to R13. -At 5:33 p.m. R13 was observed to put the empty spoon in her mouth. NA-G asked R13 if she wanted some help. R13 shook her head yes. NA-G was observed to give R13 a bite of green beans. -At 5:34 p.m. NA-G continued to assist R13 to eat the hot dish. -At 5:46 p.m. NA-G was observed to feed R13 the rest of her meal. On 7/16/14, at 7:48 a.m. R13 was observed in the dining room with 240 centimeters (cc) of water and 240 cc of apple juice placed in front of her. -At 7:58 a.m. NA-E was observed to give R13 a half a piece of toast to eat. -At 8:05 a.m. NA-E moved to the other side of the table and was assisting R24 with her meal. -At 8:06 a.m. R13 was observed to have a high cereal bowl with hot cereal in it. R13 was	F 312		

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F 312	Continued From page 24 observed to attempt to get the cereal on her spoon only to bring the empty spoon to her mouth four times. -At 8:10 a.m. R13 was observed to unsuccessfully continue to attempt to feed herself by putting the empty spoon up to her mouth several times. R13 was not able to see the cereal inside the bowl. -At 8:14 a.m. R13 put her spoon back into the bowl, and brought it to her mouth empty two more times. -At 8:15 a.m. NA-E handed R13 a piece of toast. -At 8:18 a.m. R13 was observed asleep with her half a piece of toast in her hand. NA-E was observed assisting a table mate and did not cue R13 to wake up and eat. -At 8:20 a.m. R13 remained the same. -At 8:21 a.m. NA-E told the dietary staff to keep waking R13 up. R13 was observed to finish the toast that was in her hand. -At 8:22 a.m. R13 brought the empty spoon to her mouth from the cereal bowl. -At 8:24 a.m. NA-E sat next to R13 and fed her 5 bites of cereal. NA-E gave R13 toast and handed her the juice. -At 8:25 a.m. NA-E assisted R13 to finish her meal. At 12:27 p.m. NA-E stated she felt R13 should get more help than she was receiving with eating. NA-E also stated that lately R13 was more and more sleepy and also had poor vision. In addition, NA-E stated on a good day, there would be two staff available to assist residents at R13's table to eat. However, stated there were NA call-ins that last two mornings and they were unable to replace them.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 25 At 12:58 p.m. registered nurse (RN)-A stated R13 had good and bad days. RN-A stated staff knew R13 well enough and if she was not eating they should have assisted. In addition, RN-A stated staff should also let R13 make attempts to eat on her own. RN-A confirmed R13's care plan directed staff to assist her to eat as needed and stated if R13 still had food on her plate staff should have followed the care plan and assisted her to eat. RN-A verified R13's care plan was not followed. A policy for assistance with eating was requested and none was provided.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance for 4 of 5 residents (R24, R26, R10, R14) reviewed at risk for pressure ulcers. Findings include: R24's annual Minimum Data Set (MDS) dated	F 314	Cornerstone Nursing and Rehab Center strives to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual□s condition demonstrates that they were unavoidable. A resident having pressure sores must receive necessary treatment and services to	8/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

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F 314	Continued From page 26 4/20/14, indicated R24 was diagnosed with Alzheimer's disease, had severe cognitive impairment and required total assistance with bed mobility and transfers. R24's Pressure Ulcer Care Area Assessment (CAA) dated 4/20/14, referred to the documentation in the Urinary Incontinence CAA dated 4/20/14, which indicated R24 was dependent on staff for bed mobility and was at risk for pressure ulcers. The CAA also indicted R24 was turned / repositioned at least every 2 hours and utilized a tilt and reclining wheelchair with a padded insert for proper positioning and pressure relief to decrease the risk of skin breakdown. R24's Braden Scale (a tool for predicting pressure ulcer development) dated 4/22/14, indicated R24 was at high risk for skin breakdown. R24's Tissue Tolerance Test (a tool for determining a repositioning schedule) dated 4/22/14, indicated R24 was to continue an every 2 hour repositioning schedule. R24's care plan dated 4/22/14, directed two staff to assist R24 to turn and reposition every 2 hours and as needed and off-load (reduce pressure) every 2 hours and as needed when in the wheelchair. On 7/15/14, from 5:49 p.m. until 7:22 p.m. R24 was continuously observed in the lobby seated in her wheelchair. At 7:22 p.m. nursing assistant (NA)-G was observed to assist R24 to her room. NA-G stated	F 314	promote healing, prevent infection and prevent new sores from developing. R10, R14, R24, and R26, care plans were reviewed for repositioning schedules on 8/7/14 and were current. Facility policies and procedures and documentation systems were reviewed on 8/7/14, and updates made as necessary. Nursing staff shall be educated on repositioning plans and the importance of following care plans. The DON or designee shall complete weekly random audits on repositioning of residents for 3 weeks and monthly thereafter for 3 months to ensure compliance. Results of these audits shall be reported and reviewed at the facility Quality Assurance Committee meetings for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27	F 314		

she and NA-F had placed R24 in the wheelchair at 4:00 p.m. NA-G stated normally R24 would be put to bed at 6:00 p.m. however, stated she was "running behind." NA-G verified R24 was to be repositioned every 2 hours, however, R24's wing was harder because a lot of the residents required mechanical lift transfers.
-At 7:26 a.m. NA-G was observed providing R24 evening cares. NA-G stated when they were running behind with cares they would the licensed practical nurse (LPN) know and she would help us.
-At 7:34 p.m. (3 hours & 34 minutes) later NA-F and NA-G were observed to transfer R24 to bed via the mechanical lift. NA-F stated R24 did not always get repositioned every 2 hours because there were a lot of residents on the every 2 hour schedule and they were also trying to get call lights answered.

On 7/16/14, at 6:25 a.m. R24 observed in the lobby seated in her wheelchair.
-At 6:40 a.m. R24 was observed to receive therapy in the rehab room.
-At 6:52 a.m. NA-E returned R24 to the lobby. R24 was continuously observed until 7:40 a.m.
-At 7:40 a.m. NA-E assisted R24 into the dining room. R24 was continuously observed until 8:50 a.m.
-At 8:50 a.m. NA-E assisted R24 from the dining room to Bible study. R24 was continuously observed until 9:30 a.m.
-At 9:30 a.m. NA-H stated she realized R24 was behind on her repositioning schedule. However, R24 was positioned in the Bible study so far into the group that NA-H could not remove her. NA-H stated she did not know that NA-E had brought R24 directly from the dining room to Bible study. NA-H stated R24 was placed in the wheelchair at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28 6:30 a.m. and verified she was on an every 2 hour repositioning schedule. -At 9:35 a.m. NA-H went to find another staff to assist her with R24's transfer. -At 9:45 a.m. NA-H and the physical therapy assistant were observed to transfer R24 to bed via the mechanical lift which was 3 hours & 20 minutes later. At 12:19 a.m. registered nurse (RN)-A stated R24 was at risk for skin breakdown and was to be repositioned every 2 hours. At 12:37 p.m. RN-A stated "that's no good" when told about the length of time R24 spent in the wheelchair without repositioning. RN-A stated the NAs had a list of residents and were to write down when a resident last received cares. RN-A stated R24's care plan was not followed for repositioning. R26 did not receive assistance with repositioning on the evening of 7/15/14, for 4 hours and 10 minutes. R26's Pressure Ulcer CAA dated 5/17/14, identified R26 with severe cognitive impaired and required assistance with bed mobility and toileting. R26's Tissue Tolerance Test dated 5/17/14, indicated R26 did not reposition herself consistently while in bed or in the chair and directed staff to assist with toileting needs every two hours to ensure offloading. R26's quarterly MDS dated 6/29/14, indicated R26 was diagnosed with Alzheimer's disease and osteoporosis. The MDS also indicated R26 had	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 29 severe cognitive impairment, required total assistance for bed mobility and transfers, was non ambulatory and at risk for developing pressure ulcers. R26's Braden Scale dated 7/8/14, identified R26 at risk for the development of pressure ulcers. R26's care plan dated 7/9/14, directed staff to assist R26 with repositioning every two hours. On 7/15/14, at 3:22 p.m. R26 was observed in the lobby seated in a wheelchair. - At 4:57 p.m. R26 was wheeled into the dining room for the evening meal. - At 6:05 p.m. R26 was wheeled out of the dining room and into the lobby. - At 7:35 p.m. NA-J stated she had just assisted R26 into bed. NA-J stated R26 did not have any red or open areas and confirmed R6 was incontinent of urine. She stated R26 was last assisted with repositioning at 3:20 p.m. a total of four hours and 10 minutes earlier. On 7/16/4, at 12:40 p.m. LPN-A stated R26 was to receive assistance with repositioning as directed by the plan of care. On 7/17/13, at 9:40 a.m. RN-A stated the NAs were to monitor the residents every two hours and they were to communicate between shifts to ensure all residents receive timely assistance with repositioning. R10 did not receive timely assistance with repositioning on the evening of 7/16/14, and the morning of 7/17/14.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

R10's Pressure Ulcer CAA dated 1/10/14, identified R10 at risk for the development of pressure sores and directed staff to reposition R10 every two hours.

R10's Tissue Tolerance Test dated 1/8/14, identified R10 at risk for the development of pressure ulcers and indicated R10 was able to tolerate a sitting positioning for 2 hours while in her chair without changes in skin condition.

R10's quarterly MDS dated 6/15/14, indicated R10's diagnoses included Alzheimer's dementia and seizure disorder. The MDS also indicated R10 had severe cognitive impairment, was at risk for the development of pressure ulcers and was dependent upon staff for all activities of daily living.

R10's Braden Scale dated 6/23/14, identified R10 at high risk for the development of pressure ulcers.

R10's care plan dated 7/2014, directed staff to assist R10 with repositioning every two hours while in the wheelchair.

On 7/15/14, at 3:20 p.m. R10 was observed to be assisted from bed into a wheelchair via a mechanical lift and then assisted to the dining room for a snack.
-At 3:30 p.m. R10 was wheeled to the lobby area and remained there until 4:45 p.m. at which time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31	F 314		

she was assisted to the dining room for the evening meal.
-At 6:00 p.m. R10 was observed wheeled from the dining room to the lobby area and remained there until 6:47 p.m. at which time NA-J wheeled R10 to her room for evening cares.
-At 7:05 p.m. NA-B and NA-J were observed to transfer R10 from the wheelchair into bed. R10 was observed to be incontinent of urine.
-At 7:16 p.m. NA-B confirmed R10 was last assisted with incontinence cares and repositioning at 3:20 p.m. a total of three hours and 45 minutes earlier.

On 7/16/14, at 6:40 a.m. R10 was observed in the lobby seated in a wheelchair.
-At 7:13 a.m. R10 was observed to be assisted into the dining room for breakfast.
-At 8:53 a.m. R10 was observed to be assisted from the dining room to the Bible Study activity in the day room.
-At 9:48 a.m. R10 was wheeled from the activity to the lobby area.
-At 9:49 a.m. R10 was observed to be wheeled from the lobby area to her room.
-At 9:52 a.m. staff were observed to transfer R10 from the wheelchair into bed via a mechanical lift. R10 was observed to be incontinent of urine. Her skin was pink and intact.
-At 10:10 a.m. NA-C stated R10 had not received assistance with incontinence cares or repositioning since 6:00 a.m. a total of three hours earlier.

On 7/17/14, at 9:40 a.m. RN-A stated R10 was to receive assistance with repositioning every two hours as directed by the plan of care.
R14 did not receive assistance with repositioning for 2 hours and 57 minutes on the evening of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32 7/15/14. R14's Pressure Ulcer CAA dated 12/10/13, referred to the Urinary Incontinence CAA dated 12/8/13, which indicated R14 was dependent on staff for toileting needs, was totally incontinent of bowel and bladder, and was at risk for the development of pressure ulcers. The CAA also indicated R14 was mostly dependent with cares and mobility and was at risk for skin breakdown, odor, continued dependence on others and incontinence. R14 was to be checked and changed every 2 hours and as needed in conjunction with a turning and repositioning schedule in an attempt to preserve his skin integrity. R14's quarterly MDS dated 5/18/14, indicated R14 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, was totally dependent with assistance of 2 staff for transfers and toileting and was non-ambulatory. The MDS further identified R14 was at risk of developing pressure ulcers. R14's Care Plan dated 5/22/14, directed staff R14 required assistance of two staff to turn and reposition every 2 hours while in bed and directed staff to offload R14 every two hours and as needed when in a chair. R14's Progress Note dated 7/10/14 indicated R14 had a healing stage II pressure ulcer which measured 4.0 centimeters (cm) x 2.0 cm to the right buttock. The pressure ulcer was described	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33	F 314		

as a "red area with a 1 cm open stage II to the center."

R14's Resident Admission Record dated 7/17/14, indicated R14 had diagnoses that included diabetic neuropathy, rheumatoid arthritis, spondylosis (spinal degeneration accompanied by pain) and muscle weakness.

The undated Group 3 Aid Sheet directed staff R14 was up one hour before meal time and stayed up for up to 2 hours.

On 7/15/14, at 4:39 p.m. NA-G was observed to enter R14's room and turn off his call light followed by NA-F who entered the room with a mechanical lift.
-At 5:05 p.m. R14 was observed in the dining room seated in his wheelchair. room.
-At 5:58 p.m. R14 was observed seated in his wheelchair in the lounge area. R14 was observed tilted all the way back in his tilt in space wheelchair. He remained in the lounge area until after 7:20 p.m.

At 7:20 p.m. R14 stated he had been up in his wheelchair since before supper. He stated it did get difficult sitting up in the chair at times. R14 indicated he usually sat up in the chair until he went to bed at about 8:00 p.m.

At 7:26 p.m. NA-F stated R14 had been up in his chair since before supper. She stated he got up at 4:50 p.m.

At 7:29 p.m. NA-F was observed getting R14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34	F 314		

ready for bed.
At 7:31 p.m. NA-F left R14's room to get assistance.
At 7:44 p.m. NA-F and NA-G returned to the room to complete evening cares.
At 7:47 p.m. NA-G and NA-F were observed to assist R14 into bed via a mechanical lift and and incontinence cares were provided. R14's incontinence brief was saturated with urine. R14's left buttock was observed to have an open area measuring approximately 1.0 cm in diameter surrounded by a reddened area of approximately 3.0 cm. R14's right buttock revealed a 1.0 cm reddened area without any open area observed.

At 8:00 p.m. LPN-D confirmed R14 should have been repositioned every 2 hours. LPN-D also stated they had been going back and forth with R14's repositioning schedule but confirmed it was now every 2 hours as they had been having problems with his pressure ulcers opening up again.

At 8:02 p.m. NA-G confirmed R14 was up in his chair without repositioning from 4:50 until 7:47 p.m. NA-G verified R14 should have been repositioned every two hours and off-loaded after being up in the chair for over two hours.

On 7/17/14, at 9:10 a.m. RN-B indicated the Progress Note dated 7/10/14, should have indicated R14's pressure ulcer was to the left buttock and not the right buttock. RN-B confirmed R14's care plan directed staff to reposition or offload R14 every 2 hours and stated R14 should have been repositioned or offloaded every 2 hours while in his wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35 The undated Clinical Protocol Pressure Ulcers/Skin Breakdown did not address repositioning recommendations. The undated Repositioning Policy directed the staff to provide an individualized care plan for repositioning to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely incontinence care according to their assessed needs for 6 of 6 residents (R24, R5, R26, R10, R14, R7) reviewed for urinary incontinence. Findings include: R24's annual Minimum Data Set (MDS) dated	F 315	Cornerstone Nursing and Rehab Center strives to ensure that resident□s that enter the facility without an indwelling catheter is not catheterized unless the resident□s clinical condition demonstrates that catheterization is necessary. Residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. R5, R7, R10, R14,	8/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 36 4/20/14, indicated R24 was diagnosed with Alzheimer's disease. had severe cognitive impairment and was always incontinent of urine. R24's Urinary Incontinence Care Area Assessment (CAA) dated 4/20/14, indicated R24 was dependent on staff for toileting needs and was totally incontinent of bowel and bladder. The CAA indicated R24 was to be checked and changed every 2 hours. R24's Bladder Observation dated 4/22/14, indicated R24 was checked and changed every 2 hours and as needed. R24's care plan dated 4/22/14, directed one to two staff to check and change R24's incontinent brief every 2 hours and as needed. On 7/16/14, at 6:25 a.m. R24 was observed in the lobby seated in a wheelchair. -At 6:40 a.m. R24 was observed to receive therapy in the rehab room. -At 6:52 a.m. NA-E returned R24 to the lobby. R24 was continuously observed until 7:40 a.m. -At 7:40 a.m. NA-E assisted R24 to the dining room. R24 was continuously observed until 8:50 a.m. -At 8:50 a.m. NA-E assisted R24 from the dining room to Bible study. R24 was continuously observed until 9:30 a.m. -At 9:30 a.m. NA-H stated she realized R24 was behind on her toileting schedule. However, R24 was positioned in the Bible study so far into the group that NA-H could not remove her. NA-H	F 315	R24, and R26, care plans were reviewed for incontinence schedule on 8/7/14 and were current. Facility policies and procedures and documentation systems were reviewed on 8/7/14, and updates made as necessary. Nursing staff shall be educated on toileting plans and the importance of following care plans. The DON or designee shall complete weekly random audits of timely toileting of residents for 3 weeks and monthly thereafter for 3 months to ensure compliance. Results of these audits shall be reported and reviewed at the facility Quality Assurance Committee meetings for compliance.	

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	245307	A. BUILDING _____ B. WING _____	07/17/2014

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F 315	Continued From page 37 stated she did not know that NA-E had brought R24 directly from the dining room to Bible study. NA-H stated R24 was placed in the wheelchair at 6:30 a.m. and had her brief changed at 6:20 a.m. NA-H stated R24 was to have her brief checked and changed every 2 hours. -At 9:35 a.m. NA-H went to find another staff to assist her with the transfer. -At 9:45 a.m. R24 NA-H and the physical therapy assistant were observed to transfer R24 to bed with the mechanical lift. -At 9:46 a.m. NA-H stated R24 was incontinent of urine and needed to be changed. A clean brief was applied. NA-H confirmed R24 was not provided incontinence care for 3 hours and 26 minutes. At 12:19 a.m. registered nurse (RN)-A confirmed R24 was to be checked and changed every 2 hours. At 12:37 p.m. RN-A stated the NAs had a list of all residents and were to write down when they last received cares. RN-A stated R24's care plan was not followed for incontinence care. R5 did not receive assistance with toileting for five hours on the evening of 7/15/14. R5's Urinary CAA dated 1/27/14, indicated R5 required assistance with toileting and staff were to assist R5 with toileting every two hours. R5's quarterly MDS dated 4/20/14, indicated R5	F 315		

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F 315	Continued From page 38 was diagnosed with a stroke and dementia. The MDS also indicated R5 had severe cognitive impairment, required extensive assistance with bed mobility, transfers and ambulation and was frequently incontinent of bladder. R5's Bladder Assessment dated 4/28/14, identified R5 with impaired mobility, mixed incontinence and indicated she did not feel the urge to void. The assessment indicated R5 was not appropriate for a toileting or training program related to impaired cognition and staff were to assist R5 to toilet every two hours in an attempt to decrease incontinent episodes as she did not report to the staff when she required to use the toilet. R5's care plan dated April 2014, directed staff to assist R5 with toileting every 2 hours. On 7/15/13, at 3:22 p.m. R5 was observed seated in her wheelchair in the dining room. - At 5:00 p.m. two staff members were observed to transfer R5 from the wheelchair to a standard dining room chair. -At 5:35 p.m. R5 was observed to eat her evening meal. -At 6:05 p.m. staff were observed to transfer R5 back into the wheelchair and proceeded to wheel her into the lobby area. R5 was observed to remain in the lobby until 7:30 p.m. at which time nursing assistant (NA)-B transferred R5 to the toilet via a standing lift. R5 was observed to be incontinent of urine. At 7:32 p.m. NA-B stated she had not assisted R5 with toileting since arriving at the facility at 2:30 p.m. She confirmed R5 had not received	F 315		

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F 315	Continued From page 39 assistance with incontinence cares for five hours. On 7/16/14, at 12:35 p.m. licensed practical nurse (LPN)-B stated R5 was to receive assistance with incontinence cares every two hours as directed by the plan of care. On 7/17/13. at 9:40 a.m. RN-A stated R5 was to receive assistance with incontinence cares every two hours. R26 did not receive assistance with incontinence cares on the evening of 7/15/14, for 4 hours and 10 minutes. R26's quarterly MDS dated 6/29/14, indicated R26 was diagnosed with Alzheimer's disease and had severe cognitive impairment and required total staff assistance for bed mobility and transfers, was non ambulatory and was totally incontinent of bowel and bladder. R26's Urinary CAA dated 5/17/14, identified R26 with severe cognitive impaired requiring assistance with bed mobility and toileting. The CAA indicated R26 was to receive assistance with a toileting program every two hours in an attempt to decreased incontinent episodes. R26's Bladder Assessment dated 7/8/14, indicated R26 had functional incontinence and was not appropriate for a bladder retraining program related to severe cognitive impairment. R26's care plan dated 7/9/14, directed staff to assist R26 with incontinence cares every two hours.	F 315		

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F 315	Continued From page 40 On 7/15/14, at 3:22 p.m. R26 was observed in the lobby seated in a wheelchair. - At 4:57 p.m. R26 was wheeled into the dining room for the evening meal. - At 6:05 p.m. R26 was wheeled out of the dining room and into the lobby. - At 7:35 p.m. NA-J stated she had just assisted R26 into bed. NA-J stated R26 did not have any red or open areas and confirmed R6 was incontinent of urine. She stated R26 was last assisted with repositioning at 3:20 p.m. a total of four hours and 10 minutes earlier. On 7/16/4, at 12:40 p.m. LPN-A stated R26 was to receive assistance with incontinence cares every two hours as directed by the plan of care. On 7/17/13, at 9:40 a.m. RN-A stated the nursing assistants were to monitor the residents every two hours and were to communicate between shifts to ensure all residents received timely assistance with incontinence cares. R10 did not receive timely assistance with incontinence cares on the evening of 7/16/14, and the morning of 7/17/14. R10's Urinary CAA dated 1/10/4, indicated R10 was totally incontinent of bowel and bladder and directed staff to check and change R10's incontinent brief every two hours and as needed in an attempt to preserve her skin integrity. R10's quarterly MDS dated 6/15/14, indicated R10 was diagnosed with Alzheimer's dementia and seizure disorder. The MDS also indicated R10 had severe cognitive impairment, was	F 315		

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F 315	Continued From page 41 dependent upon staff for all activities of daily living and was totally incontinent of bladder. R10's care plan dated 7/2014, directed staff to assist R10 with incontinence cares every two hours. On 7/15/14, at 3:20 p.m. R10 was observed to be assisted from bed into a wheelchair via a mechanical lift and then assisted to the dining room for a snack. -At 3:30 p.m. R10 was wheeled to the lobby area and remained there until 4:45 p.m. at which time she was assisted to the dining room for the evening meal. -At 6:00 p.m. R10 was observed wheeled from the dining room to the lobby area and remained there until 6:47 p.m. at which time NA-J wheeled R10 to her room for evening cares. -At 7:05 p.m. NA-B and NA-J were observed to transfer R10 from the wheelchair into bed. R10 was observed to be incontinent of urine. -At 7:16 p.m. NA-B confirmed R10 was last assisted with incontinence cares and repositioning at 3:20 p.m. a total of three hours and 45 minutes earlier. On 7/16/14, at 6:40 a.m. R10 was observed in the lobby seated in a wheelchair. -At 7:13 a.m. R10 was observed to be assisted into the dining room for breakfast. -At 8:53 a.m. R10 was observed to be assisted from the dining room to the Bible Study activity in the day room. -At 9:48 a.m. R10 was wheeled from the activity to the lobby area. -At 9:49 a.m. R10 was observed to be wheeled from the lobby area to her room. -At 9:52 a.m. staff were observed to transfer R10	F 315		

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F 315	Continued From page 42 from the wheelchair into bed via a mechanical lift. R10 was observed to be incontinent of urine. Her skin was pink and intact. -At 10:10 a.m. NA-C stated R10 had not received assistance with incontinence cares or repositioning since 6:00 a.m. a total of three hours earlier. On 7/17/14, at 9:40 a.m. RN-A stated R10 was to receive assistance with incontinence cares every two hours as directed by the plan of care. R7 did not receive assistance with toileting for 3 hours and 9 minutes on the morning of 7/16/14. R7's Urinary CAA dated 2/9/14, indicated R7 required assistance with toileting, was at risk for the development of pressure ulcers, and was frequently incontinent of bowel and bladder. It also indicated R7 was on a toileting schedule of every two hours and as needed or requested in an attempt to decrease incontinent episodes and decrease the risk of skin breakdown. R7's quarterly MDS dated 5/4/14, identified R7 with severe cognitive impairment. The MDS also identified R7 required extensive assist of one for transfers and toilet use and he was frequently incontinent of bowel and bladder. R7's Care Plan dated May 2014, indicated R7 was frequently incontinent of bowel and bladder and required assist of one with toileting. The care plan directed staff to empty urinal as directed and encourage toileting schedule of every 2 hours and as needed or requested by R7. R7's Resident Admission Record dated 7/17/14, indicated R7 had diagnoses that included kidney calculus (kidney stone), hydronephrosis (swollen	F 315		

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F 315	Continued From page 43	F 315		

kidney due to the failure of normal drainage of urine from the kidney to the bladder), and benign prostatic hypertrophy (enlargement of the prostate) without urinary obstruction.

The Group 1 Aid Sheet directed staff to assist R7 every 2 hours with toileting.

On 7/16/14, from 7:34 a.m. until 10:41 a.m., R7 was continuously observed.
-At 7:34 a.m. NA-A and NA-E were observed exiting R7's room. R7 was observed seated in a wheelchair in front of an over bed table independently eating breakfast.
-At 9:06 a.m. NA-C was observed to remove R7's breakfast tray from R7's room. R7 was observed to remain seated in the wheelchair watching television.
-At 10:00 a.m. NA-D was observed to enter R7's room briefly and exit.
-At 10:41 a.m. NA-A stated she didn't usually work with R7 and she wasn't sure how often he should be checked but stated he wore a brief and she thought he was sometimes incontinent. NA-A then asked R7 if he needed the bathroom. R7 refused and NA-A left the room without checking for incontinence.

At 10:43 a.m. NA-C confirmed R7 was incontinent and wore a brief. She stated he was to be checked every 2 hours. NA-C stated she had not checked R7 for incontinence since he got up that morning. NA-C entered R7's room to assist him to dress.

At 10:57 a.m. NA-C stated R7's incontinent brief was wet when she went in to assist him to dress. She stated there were no skin concerns and if there were she would contact the nurse.

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F 315	Continued From page 44 At 11:00 a.m. NA-D stated she had offered R7 a bath at 10:00 a.m. which he refused. She stated she did not do anything else for R7 and he did not request anything. NA-D stated she did not check, change or offer R7 the toilet when she offered him his bath. On 7/17/14, at 2:17 p.m. RN-A confirmed R7 should have been checked for incontinence and changed or offered the toilet every 2 hours as directed by the care plan. R14 did not receive assistance with toileting for 2 hours and 57 minutes on the evening of 7/15/14. R14's Urinary CAA dated 12/8/13, indicated R14 was dependent on staff for toileting needs, was totally incontinent of bowel and bladder and was at risk for the development of pressure ulcers. It also indicated R14 was to be checked and changed every 2 hours and as needed in conjunction with a turning and repositioning schedule in an attempt to preserve his skin integrity. R14's quarterly MDS dated 5/18/14, indicated R14 had moderate cognitive impairment, was always incontinent of bladder and bowel and was totally dependent with assistance of 2 staff for transfer and toileting. R14's Care Plan dated 5/22/14, indicated R14 wore an incontinent brief at all times, required the	F 315		

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F 315	Continued From page 45 assist of 2 staff and directed staff to check and change R14 every 2 hours and as needed. The Group 3 Aid Sheet directed to check and change R14 every 2 hours. R14's Resident Admission Record dated 7/17/14, indicated R14 had diagnoses that included diabetic neuropathy, renal failure, benign prostatic hypertrophy without urinary obstruction, and rheumatoid arthritis. On 7/15/14, at 4:39 p.m. NA-G was observed to enter R14's room and turn off his call light followed by NA-F who entered the room with a mechanical lift. -At 5:05 p.m. R14 was observed in the dining room seated in his wheelchair. room. -At 5:58 p.m. R14 was observed seated in his wheelchair in the lounge area. R14 was observed tilted all the way back in his tilt in space wheelchair. He remained in the lounge area until after 7:20 p.m. At 7:20 p.m. R14 stated he had been up in his wheelchair since before supper. He stated it did get difficult sitting up in the chair at times. R14 indicated he usually sat up in the chair until he went to bed at about 8:00 p.m. At 7:26 p.m. NA-F stated R14 had been up in his chair since before supper. She stated he got up at 4:50 p.m. At 7:29 p.m. NA-F was observed getting R14 ready for bed. At 7:31 p.m. NA-F left R14's room to get assistance.	F 315		

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F 315	Continued From page 46 At 7:44 p.m. NA-F and NA-G returned to the room to complete evening cares. At 7:47 p.m. NA-G and NA-F were observed to assist R14 into bed via a mechanical lift and incontinence cares were provided. R14's incontinence brief was saturated with urine. At 8:00 p.m. LPN-D confirmed R14 should have been toileted every 2 hours. At 8:02 p.m. NA-G confirmed R14 was up in his chair without incontinent cares from 4:50 until 7:47 p.m. and stated R14 should have been checked and changed every two hours. On 7/17/14, at 9:10 a.m. RN-B confirmed R14's care plan indicated R14 should be checked for incontinence and changed every 2 hours and stated he should have been. The undated Behavioral Program and Toileting Plan for Urinary Incontinence policy directed the staff to assist residents with toileting plans as directed on their individual bladder assessments. The undated Urinary Incontinence policy directed staff to provide scheduled toileting, prompted voiding or other interventions to try to improve the individuals toileting ability.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		8/26/14

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F 329	Continued From page 47 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continued use of antianxiety medication for 1 of 2 residents (R16) who received antianxiety medication. In addition, the facility failed to document the clinical rational for the combined use of two antidepressants for 1 of 1 resident (R7) receiving antidepressant medications Findings include: R16 had received a new antianxiety medication without comprehensive monitoring of the medication.	F 329	Cornerstone Nursing and Rehab Center strives to maintain unnecessary drug regimens for our residents. Ensuring that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. R16□s care plan shall be updated to reflect monitoring after any medication additions, changes,	

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F 329	Continued From page 48 R16's quarterly Minimum Data Set (MDS) dated 6/8/14, indicated R16 was diagnosed with dementia, anxiety and depression. The MDS indicated R16 had severe cognitive impairment, required extensive assistance with all activities of daily living and displayed little interest in doing things and displayed physical and verbal behaviors towards others. Review of the Clinic Referral form dated 6/9/14, indicated R16 was seen by the primary physicians and was diagnosed with anxiety and depression therefore was prescribed Klonopin (an antianxiety medication) 0.5 milligrams twice a day. On 6/11/14, the Nurse To Provider Fax Form indicated R16 was unable to stay awake through the day. The physician responded by changing the Klonopin order to 0.5 mg at bedtime and as needed. On 6/16/14, the nurses again sent a fax to the physician which indicated R16 was extremely tired and lethargic during the morning after receiving the Klonopin at bedtime. The physician changed the time of the medication to 4:00 p.m. R16's care plan dated 6/2014, indicated R16 displayed physical and verbal behaviors towards others, felt she would be better off dead and had impaired abilities to understand others. The plan directed staff to attempt to explain procedures, allow R16 to cool off and reapproach if she displayed behaviors and to provide R16 a safe environment if she became aggressive.	F 329	or discontinuation. Medication monitoring system shall also be updated. Nursing staff shall be educated on updated and current policies and procedures. R7□s care plan shall be reviewed and updated as needed to ensure resident continues to be monitored for aggressive behaviors that warrant medication usage. Nursing staff shall be educated on carefully monitoring orders from the physicians to include a clinical rationale for all medications prescribed. The DON or designee shall complete monthly random audits of medication orders for 3 months to ensure compliance. Results of these audits will be reported and reviewed at the facility Quality Assurance Committee meetings.	

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	245307	A. BUILDING _____ B. WING _____	07/17/2014

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CORNERSTONE NSG & REHAB CENTER	**416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 49	F 329		

Review R16's Progress Notes (nurse's documentation) indicated on 6/29/14, 7/5/14, 7/12/14, 7/13/14, and 7/14/14, R16 had became verbally aggressive towards staff and visitors. The verbal outburst were quick interactions. The record did not contain follow up documentation after the aggressive moments.

On 7/16/14, from 7:00 a.m. to 12:00 p.m. R16 was observed to sleep in her wheelchair. Staff were observed to wake R16 repeatedly during the breakfast meal to encourage her to eat.

On 7/16/14, at 12:40 a.m. licensed practical nurse (LPN)-B stated R16 would be very pleasant one moment and then escalate into yelling at others the next moment. LPN-B stated staff were to document when R16 displayed behaviors and the registered nurses (RN) were to evaluate R16's responses to the medication.

On 7/17/14, from 6:30 a.m. to 12:00 p.m. R16 was observed to sleep in her wheelchair and staff repeatedly attempt to waken her.

On 7/17/14, at 10:00 a.m. RN-B stated RN-D was monitoring R16 and her response to the medication adjustments. RN-B confirmed R16 continued to be very lethargic during the morning hours. She stated R16 did not fully waken until after she had taken a rest after lunch. RN-B confirmed R16's medications should have been re-evaluated because of excessive day time sleeping. RN-B confirmed RN-D had not documented any medication responses on R16 since the medication was added on 6/9/14.

On 7/17/14, at 1:45 p.m. LPN-B stated the medication reviews had been completed by a

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F 329	Continued From page 50 former employee. She confirmed she had noticed R16 was sleeping more since the medication was started in 6/2014. RN-D was attempted to be contacted by phone and was not available during the survey. The undated Psychotropic Medication Policy and Procedure directed staff to monitor the efficacy and side effects on a daily basis for six weeks upon the initiation of psychotropic medication with dose reductions or discontinuation of the medication. R7 received two antidepressant medications without clinical rationale for the combined use. R7's quarterly MDS dated 5/4/14, identified R7 with severe cognitive impairment and his Resident Admission Record dated 7/17/14, indicated he had diagnoses that included depressive disorder. R7's Psychotropic Drug Use Care Area Assessment (CAA) dated 2/9/14, referred to the Falls CAA which indicated fall and psychotropic drug use triggered related to impaired balance without assistance with transitions and receiving psychotropic medications. R7 had the diagnoses of anxiety and depression. He received Prozac, Wellbutrin, and Klonopin for management. The CAA also indicated R7 had no negative side effects reported or documented with use of current medications and the consulting pharmacist reviewed medications monthly and made recommendations as appropriate. The CAA further indicated changes and concerns were reported to the provider.	F 329		

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F 329	Continued From page 51 R7's Physician Order Report dated 6/17/14, to 7/17/14, identified orders for Prozac 40 milligrams (mg) once a morning, which started 5/16/13, and Wellbutrin XL 150 mg once daily, which started 1/15/14. The Consultant Pharmacist's Medication Review dated January 2014, indicated R7 was using two routine antidepressants and requested clear documentation of the risks versus benefits of the continued use of two routine antidepressants or to rule out the possibility to manage depression with a single agent. The physician rejected the recommendation on 2/26/14, however, did not document a rationale for the continued use of two medications in the record. On 7/17/14, at 2:17 p.m. RN-A confirmed there was no documentation available indicating a clinical rationale for the use of two antidepressant medications for R7.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		8/26/14

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F 441	Continued From page 52 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed by the nurse for 1 of 1 resident (R55) observed during wound care. In addition, the facility failed to track, trend and analyze resident infections. This had the potential to affect all 40 residents residing in the facility. Findings include: R55's physician progress notes dated 7/8/14, indicated R55 had surgery for a perforated gastric	F 441	Cornerstone Nursing and Rehab Center strives to continuously institute and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection to its residents, employees, and visitors. LPN-A who provided cares to R55 has been educated, along with all nursing staff, on current and updated policies. The facility Infection Control policies and procedures have been reviewed and updated. Tracking and trending shall be	

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F 441	Continued From page 53 ulcer complicated by an intra-abdominal abscess (an accumulation of pus). The progress note also indicated R55 was diagnosed with Clostridium Difficile (C-DIFF) (a spore which causes watery diarrhea). R55 was on contact isolation (a form of isolation where anyone entering the room wears a gown and gloves). On 7/17/14, at 10:00 a.m. licensed practical nurse (LPN)-A was observed to gather R55's abdominal surgical wound dressing supplies. Prior to entering the room, LPN-A applied an isolation gown, mask and gloves. LPN-A was observed to remove the soiled abdominal wound dressing and rinse the wound with normal saline. LPN-A placed gauze into the abdomen with a sterile Q-tip and cleaned out the wound. With the same gloves, LPN-A opened a clean 4 x 4 gauze pad and tucked it into the wound with a sterile Q-tip and covered the wound with an abdominal pad. LPN-A proceeded to remove her gown, gloves and mask while in the room and as she exited R55's room she was observed to use hand sanitizer which was placed outside of the room. At no time during the dressing change did LPN-A change her gloves or wash her hands. At 10:05 a.m. LPN-A stated she should have changed her gloves and washed her hands before applying the clean dressing. LPN-A stated she was busy and was not thinking clearly. LPN-A stated, "I knew I had done it wrong." LPN-A stated their policy was to wash hands after glove removal. At 11:06 a.m. registered nurse (RN)-B stated when going from dirty to clean the gloves should have been removed and hands washed according to the policy. RN-B also stated hand	F 441	updated to reflect current trends and tracking within the facility. The DON or designee shall complete weekly random audits of employee hand washing and glove use for 4 weeks and monthly thereafter for 3 months to ensure compliance is maintained. The Quality Assurance Committee shall be responsible for ensuring compliance through monitoring of the audits and the Infection Control program through the tracking and trending reports.	

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	245307	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 54 washing should have been done when the dressing change was completed versus using hand sanitizer. At this time, the administrator instructed RN-B to educate LPN-A about hand washing. The undated Glove policy read, wash hands after removing gloves. INFECTION CONTROL (IC) PROGRAM: On 7/17/14, at 1:13 p.m. RN-B stated she was hired a month ago and worked 3 days a week. RN-B stated today was the first time she had seen the IC book. RN-B stated the new director of nursing (DON) was starting 8/4/14. RN-B stated she did not know at this point who would be in charge of infection control. According to the infection control log resident infections had been tracked and trended through the end of April 2014. RN-B confirmed resident infections had not been tracked or trended nor analyzed since May 1st. An infection control surveillance policy was requested and RN-B stated none was found.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		8/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 55 by: Based on observation and interview, the facility failed to maintain resident room walls and bathroom toilets in a clean and sanitary condition for 11 of 11 residents (R15, R16, R39, R13, R2, R19, R10, R54, R36, R12, R26,) identified with concerns in their rooms. Findings include: On 7/17/14, at 8:40 a.m. a facility tour was completed with the environmental supervisor (ES). The ES stated was employed at the facility for about 2 weeks. The following items were observed during the tour: -R15 and R16 shared a common bathroom. The bathroom wall was observed lacking paint. An area 38 inches wide and an area 29 inches wide were not painted. The ES stated the other maintenance staff had started the project in the bathroom and had not finished. The ES stated he was not aware the bathroom paint was lacking. In addition, the white caulking around the base of the toilet stool had black marks on it. The ES stated it looked like dirt had been mixed in with the caulking. -R39's room was observed to have a 14 inch x 14 inch area on the west wall with no paint. The ES stated he was not aware of this area. In addition, another 12 inch x 12 inch area on west wall also lacked paint. The white caulking around the base of the toilet stool had black marks on it -R13's door to the room had a 12 inch strip where the stain was missing from the door. In addition, the white caulking around the base of the toilet stool had black marks on it.	F 465	Cornerstone Nursing and Rehab Center shall provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Maintenace shall paint the area in the shared bathroom wall between R15 and R16, an area on the west wall in the room of R39, an area in the bathroom of R54, and an area on the south wall in the dining room. The white caulking around the base of the toilet stool shall be replaced with new caulking in resident bathrooms of R15, R16, R39, R13, R2, R19, R10, R54, R36, R12, and R26. The door leading to the room of R13 shall be stained. The bathroom door of R36 and R12 shall have the gouge repaired in the wooden door, and stained. The cracked tiles shall be replaced. The mop boards in the bathrooms of R54 and R26 shall be repaired or replaced. The beauty shop door has never been painted and is wooden, however, shall be cleaned and polished. A preventative maintenance program policy and procedures has been developed and implemented. The Environmental Services Supervisor shall complete weekly facility inspections, including resident rooms and bathrooms to ensure a safe, clean, homelike environment. The Quality Assurance Committee shall complete random audits to monitor and ensure ongoing compliance.	

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F 465	Continued From page 56 -R2's toilet stool was observed to have black marks on the white caulking. -R19 and R10, shared a common bathroom. The toilet stool caulking was observed to have black marks on it. - R54 had a missing mop board in the bathroom. In addition, a 16 inch area was not painted in the bathroom. The toilet stool was observed to have black marks on the white caulking that was chipped around the toilet. -R36 and R12, shared a common bathroom. The door going into the bathroom, had a 1-1/4 inch gouge out of the wooden door. In addition, there was a 19 inch area on the door missing stain. There were cracks in the three bathroom tiles, measuring 12 inches x 12 inches. The toilet stool was observed to have black marks on the white caulking. -R26 had a missing mop board in the bathroom, measuring 2 inches x 1-/1/2 inch. In addition, the toilet stool was observed to have black marks on the white caulking. -The door to the beauty shop was missing paint. -At 9:36 a.m. the south wall of the dining room was missing paint. In addition, there were black marks on the existing paint. At 9:32 a.m. the ES stated he was not aware of a maintenance policy regarding upkeep of the building. The ES stated he would be changing the format of everything and would be including a policy.	F 465		

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F 465	Continued From page 57 At 10:07 a.m. the administrator stated she could have used the maintenance person months ago. She added, she felt confident all the findings would be taken care of.	F 465		

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/16/2014**

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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. At the time of this survey, Cornerstone Nursing and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

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

Electronically Signed | 08/06/2014

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

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K 000	Continued From page 1 Marian.Whitney@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 The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. The building is divided into 3 smoke compartments by 30 minute fire barriers. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection is in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have battery operated smoke detectors installed. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code (2007 edition). The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a	K 000		

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/16/2014**

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K 000	Continued From page 2 census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include:	K 029	Self closing hinges were installed on the 100 and 200 wing soiled linen utility room doors. Upon installation, each door was tested to ensure each positively closes and latches into the door frames. The Environmental Services Supervisor shall complete random checks on all self closing doors to ensure each one properly closes and latches.	8/4/14

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/16/2014**

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K 029	Continued From page 3 On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, observation revealed, that the soiled linen utility rooms located in the 100 and 200 wing had doors that were not self closing and did not positively close and latch into the door frames. This deficient practice was verified by the Maintenance Supervisor (PJ).	K 029		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, during the review of all available maintenance documentation and interview with the Maintenance Supervisor (PJ) the facility could not locate or provide any maintenance documents for the annual 90 minute test for the battery backup emergency lighting within the last 12 months. The facility also could not locate or provide any documentation for the 30 second	K 046	A 90 minute test shall be completed annually, and a 30 second test completed monthly on all battery-operated emergency lights. The exit emergency lights are tied into the facility emergency generator which shall also be tested monthly. A test log has been created and implemented to ensure timely completion and documentation is maintained. The Environmental Services Supervisor is responsible for ensuring compliance.	8/26/14

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/16/2014**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 4 monthly testing of the battery backup emergency lighting within the last 12 months. These deficient practices were verified by the Maintenance Supervisor (PJ).	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, during the review of all available maintenance documentation and interview with the Maintenance Supervisor (PJ) the facility could not locate or provide any records or	K 050	Fire drills were conducted on each shift on June 30th, 2014 and the fire alarm sounded on the same day for compliance in the 2nd quarter. Fire drills shall be conducted on each shift quarterly and the alarm tested each month. A schedule has been created and implemented for the remainder of the year, by month, shift, and location. The Environmental Services Supervisor shall follow the schedule to ensure compliance with fire drills and testing of the fire alarm.	8/26/14

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/16/2014**

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K 050	Continued From page 5 documentation for 9 of 12 fire drills being held during the last 12-month period. This deficient practice was verified by the Maintenance Supervisor (PJ).	K 050		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to maintain the	K 051	All manually actuated alarm-initiating devices shall maintain unobstructed	8/26/14

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K 051	Continued From page 6 unobstructed access to 2 of several manually actuated alarm-initiating devices located throughout the facility in accordance with NFPA 101 Life Safety Code (00), Sections 19.3.4.2 and 9.6.2.6 as well as NFPA 72 National Fire Alarm Code (99), Sections 2-8.2.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, observation revealed, that 2 of several manual fire alarm pull station did not meet the requirements of both the NFPA 101 (00) and the NFPA 72 (99) that require manual fire alarm stations shall be unobstructed and accessible at all times. The obstructed manual fire alarm pull stations were found in the following locations: 1. In the lower level mechanical/boiler room located behind electrical conduit behind the facility's emergency generator, and 2. In the activities room by the exit door that was blocked by furniture and wheelchairs. These deficient practices were verified by the Maintenance Supervisor (PJ).	K 051	access. The electrical conduit shall be relocated in the boiler/mechanical room. The furniture and wheelchairs near the exit door in the activities room were moved to create unobstructed access to the manual alarm. The Environmental Services Supervisor shall be responsible for ensuring all alarm-initiating devices have unobstructed access.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		8/26/14

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K 052	Continued From page 7 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, observations revealed the smoke detectors located in the 100 wing corridor by resident rooms 108 and 113 were installed within 36 inches of HVAC diffusers. This deficient practice was verified by the	K 052	The smoke detectors in the 100 wing corridor shall be relocated at a distance of a minimum of 36 inches of HVAC diffusers. In the event there is a change to the physical structure, resulting in the location of smoke detectors, the Environmental Services Supervisor shall ensure proper placement for compliance.	

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K 052	Continued From page 8 Maintenance Supervisor (PJ).	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on a staff interview and a review of the available documentation, the facility has not conducted that required testing of the battery-operated smoke detectors on the fire alarm system in accordance NFPA 72 (99) Section 7-4 and with the Manufacturer's instructions. This deficient practice could affect residents, visitors, and staff. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, it was observations the facility has battery-operated smoke detectors installed in the resident rooms located throughout the facility. Further observations made during the documentation review revealed that the facility could not locate or provide documentation for the weekly or monthly testing of the batter-operated smoke detector. This deficient practice was verified by the Maintenance Supervisor (PJ).	K 054	Cornerstone Nursing and Rehab Center is fully sprinkled, therefore, all battery-operated smoke detectors have been removed and taken out of service.	8/6/14
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		8/26/14

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K 056	Continued From page 9 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, observations have reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. There wires attached to the fire sprinkler piping that is located in the lower level corridor and within the laundry room.	K 056	All wires shall be relocated away from the sprinkler piping in the lower level corridor and within the laundry room. Additional spare sprinkler heads have been ordered. All types of sprinkler heads in the facility shall have spare heads located in the Maintenance/boiler room. Two existing sprinklers were removed, one from the laundry room and the other from the laundry chute. A new sprinkler head was installed in the laundry chute, which was then tied into the existing sprinkler system and monitored by the fire alarm system. The Environmental Services Supervisor shall ensure compliance through appropriate service and parts on the facility sprinkler system by maintaining documentation of annual inspection of the sprinkler system.	

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K 056	Continued From page 10 2. The facility is missing spare fire sprinkler heads from the fire sprinkler spare head box located at the fire sprinkler riser on the lower level. The missing heads are the sidewall style heads that are located in the activities room. 3. There are 2 fire sprinkler heads one that is located at the top of the linen chute and one in the linen chute room on the lower level that are part of a domestic water line and are not monitored by the fire alarm system. The domestic water line sprinkler head in the chute room on the lower level is a located within 18 inches of a head that is part of the facility's automatic fire sprinkler system that is tied in the fire alarm system. The activation of the domestic head could cause the cold soldering of the sprinkler head that is part of the facility's automatic fire sprinkler system causing a lack of adequate fire suppression coverage and would delay the fire alarm activation and notification for the facility in the event of a fire. These deficient practices were verified by the Maintenance Supervisor (PJ).	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		8/26/14

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K 062	Continued From page 11 Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, a review of documentation and interview with the Maintenance Supervisor (PJ), revealed the facility could not locate or provide documentation for the 3 of 4 quarterly fire sprinkler flow tests required by NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Maintenance Supervisor (PJ).	K 062	A quarterly fire sprinkler flow test shall be completed by the Environmental Services Supervisor. A record log has been created and initiated for maintaining accurate record of timely quarterly fire sprinkler flow tests, as part of the preventative maintenance program. The Environmental Services Supervisor shall be responsible for ensuring timely testing and documentation records.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067		8/26/14

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K 067	Continued From page 12 Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor (PJ), that the facility could not locate or provide any documentation that the fire and smoke dampers have been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient practice was verified by the Maintenance Supervisor (PJ).	K 067	Cornerstone Nursing and Rehab Center is equipped with one smoke damper. This damper shall be inspected and tested at a minimum of every 4 years. A log has been created and initiated to reflect smoke damper testing every 4 years. The Environmental Services Supervisor shall be responsible for ensuring timely tests and inspections through maintaining proper documentation as part of the preventative maintenance program.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility had deficient practice that are in violation of the Minnesota State Fire Code (07). These deficient conditions could affect residents,	K 130	The Environmental Services Supervisor has cleaned the lint in the back of both dryers and shall continue to maintain the cleanliness of the dryer areas to ensure a	8/26/14

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K 130	Continued From page 13 visitors, and staff in the event of a fire. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, the following deficient conditions were observed that are in violation with multiple sections of the Minnesota State Fire Code (07): 1. The 2 cloths dryers that are located in the facility's laundry room had excessive lint buildup within the combustion area in the back of the dryers. The lint was observed to be between 3/8 to 1/2 of an inch in thickness. The condition is in violation of the Minnesota State Fire Code (07) sections 305.1. 2. There is a horizontal liquid propane storage container that is located outside of the building within 24 inches of the building exterior wall on one side and the parking lot on the other side of the cylinder. The liquid propane cylinder is not protected from vehicle impact as required by the Minnesota State Fire Code (07) sections 312, 2703.9.3, and 3003.5.2. These deficient practices were verified by the Maintenance Supervisor (PJ).	K 130	safe environment. The weekly preventative maintenance log has been updated to include the cleaning of lint to the back of the dryers. Cement pillars shall be installed near the propane tank to protect from potential vehicle impact. The Environmental Services Supervisor is responsible for ensuring compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		8/26/14

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K 144	Continued From page 14 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all residents, staff, and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM on 07/16/2014, documentation review of the emergency generator testing logs indicated that the facility could not locate or provide documentation for 6 of 12 monthly inspection and 6 months worth of weekly inspections of the generator. These deficient practices were verified by the Maintenance Supervisor (PJ).	K 144	The facility emergency generator shall be inspected weekly and exercised under load for 30 minutes each month. The Emergency Power Generator Test Log has been reviewed and updated to reflect required documentation. The Environmental Services Supervisor is responsible for ensuring compliance.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 31, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S533307024,

Dear Ms. Swanson:

The above facility was surveyed on July 14, 2014 through July 17, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File