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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P9P3

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 **04/25/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Theresa Gullingsrud, HFE NEII 07/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/08/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
05/01/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5307

On April 6, 2017 and April 25, 2017, the Departments of Public Safety and Health completed revisits to verify correction of deficiencies issued pursuant to the March 7, 2017 extended survey. Based on the revisits, we have determined the facility corrected all deficiencies, effective April 15, 2017. As a result, the Department discontinued the Category 1 remedy of State monitoring as of April 15, 2017.

In addition, we recommended that the CMS Region V office impose a civil money penalty for deficiency cited at F323.

The facility would be subject to a two year loss of NATCEP beginning March 7, 2017, due to the extended survey that identified substandard quality of care.

Effective April; 15, 2017, the facility is certified for 43 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245307

July 18, 2017

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

Dear Mrs. 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective April 15, 2017 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
Health Regulation Division
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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

CMS Certification Number (CCN): 245307

June 30, 2017
By Certified Mail

Mrs. Kari Swanson, Administrator
Cornerstone Nursing & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

Dear Mrs. Swanson:

SUBJECT: SURVEY RESULTS AND IMPOSITION OF CIVIL MONEY PENALTY
Cycle Start Date: March 7, 2017

SURVEY RESULTS
On February 28, 2017, a Life Safety Code (LSC) and on March 7, 2017, a health survey were completed at Cornerstone Nursing & Rehab Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys revealed that your facility was not in substantial compliance and found the most serious deficiency to place the health and safety of your patients in immediate jeopardy. This deficiency was cited as follows, including the level of Scope and Severity (S/S):

- F323 -- S/S: J -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices

In addition, the above cited deficiency constituted Substandard Quality of Care (SQC), and an extended survey was performed.

Surveyors found a situation of immediate jeopardy to patient health and safety that was removed on March 6, 2017. However, they also found that your facility continued not to be in substantial compliance with Federal requirements

- F279 -- S/S: E -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans
- F282 -- S/S: E -- 483.21(b)(3)(ii) -- Services By Qualified Persons/Per Care Plan
- F497 -- S/S: E -- 483.35(d)(7) -- Nurse Aide Perform Review-12 Hr/Yr Inservice

The MDH advised you of the deficiencies noted above and provided you with a copy of the survey report (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid

Services (CMS), the MDH notified you on March 22, 2017, of the imposition of the following remedy, as well as your appeal rights

- State monitoring effective March 28, 2017
- Mandatory denial of payment for new admissions effective June 7, 2017

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

The MDH notified you they were recommending that the CMS impose an additional remedy. We concur with the MDH's recommendation and are imposing the following remedy:

- Federal Civil Money Penalty effective March 7, 2017
- Mandatory termination effective September 7, 2017

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

On April 6, 2017 and April 25, 2017, the MDH conducted a revisit of your facility and found that

your facility was in substantial compliance as of April 15, 2017. As a result, the final status of remedies is as follows:

- State monitoring, which was imposed effective March 28, 2017, is discontinued effective April 15, 2017
- Mandatory denial of payment for new admissions, which was to be effective June 7, 2017, is rescinded
- Mandatory termination, which was to be effective September 7, 2017, will not be imposed
- See Civil Money Penalty below

CIVIL MONEY PENALTY

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

- Federal Civil Money Penalty of $11,752 per instance for the instance of noncompliance at F323 (S/S: J) identified in the CMS-2567 survey ending March 7, 2017

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

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

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

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

CMP REDUCED IF HEARING WAIVED

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

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

CMP CASE NUMBER

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

- Your CMS Certification Number (CCN) is **245307**
- The start date for this cycle is **March 7, 2017**

CMP PAYMENT

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

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

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

Because your facility was subject to an extended survey, this provision is applicable to your facility. Therefore, Cornerstone Nursing & Rehab Center is prohibited from offering or conducting a NATCEP for two years from March 7, 2017. You will receive further information regarding this from the MDH. This prohibition remains in effect for the specified period even though other actions relating to remedies are being taken, as indicated above. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

The MDH previously advised of your right to appeal the noncompliance that resulted in the finding of SQC which resulted in the loss of NATCEP approval. Please refer to that notice and note the deadline for that appeal. This formal notice a CMP. If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a

hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 18, 2017

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

RE: Project Number S5307027

Dear Mrs. Swanson:

On March 22, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 28, 2017. (42 CFR 488.422)

In addition, on March 22, 2017, we informed you that we were recommending that CMS impose an additional remedy. CMS concurred and on June 30, 2017, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty for the deficiency cited at F323, effective March 7, 2017. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 7, 2017. (42 CFR 488.417 (b))

- Mandatory termination effective September 7, 2017 (42 CFR Sections 488.412 and 488.456488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on March 7, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On April 25, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 4, 2017 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 an extended survey, completed on March 7, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2017.

We have determined, based on our visits, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on March 7, 2017, as of April 15, 2017.

As a result of the revisit findings and as notified by the CMS on June 30, 2017, the Department discontinued the Category 1 remedy of state monitoring effective April 15, 2017.

In addition, on June 30, 2017, the CMS Region V Office notified you of the following actions related to the imposed remedies:

- Civil money penalty for the deficiency cited at F323, effective March 7, 2017, was being imposed (See CMS notice dated June 30, 2017). (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 7, 2017, was being rescinded. (42 CFR 488.417 (b))

- Mandatory termination effective September 7, 2017, was being rescinded. (42 CFR Sections 488.412 and 488.456488.417 (b))

Furthermore, as we notified you in our letter of March 22, 2017 and CMS notified you in their notice of June 30, 2017, because your facility was subject to an extended survey, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 7, 2017. However, under Public Law 105 - 15, you may contact the Department and request a waiver of this prohibition if certain criteria are met.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P9P3

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 **03/07/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Lisa Carey, HFE NEII 04/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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:

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. We also verified on March 6, 2017 and March 7, 2017, that the conditions resulting in our notification of two separate immediate jeopardy situations, have been removed.

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. The facility meets this criterion. Therefore, this Department is imposed the following remedy:

• State Monitoring effective March 27, 2017. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The facility would be subject to a two year loss of NATCEP beginning March 7, 2017 as a result of the extended survey that identified substandard quality of care.

Refer to the CMS 2567 for both health and life safety code, along with the facilitys plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 23, 2017

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

RE: Project Number S5307027

Dear Mrs. Swanson:

On March 7, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified on March 6, 2017 and March 7, 2017, that the conditions resulting in our notification of two separate immediate jeopardy situations, have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 27, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations. and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. ***If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care***.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Cornerstone Nsg & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 7, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 7, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 7, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245307	A. BUILDING: _____ B. WING _____	3/7/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 492	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD

(b) Compliance with Federal, State, and Local Laws and Professional Standards.

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to Other HHS Regulations.

In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to stop billing during the appeals process for 1 of 1 resident (R36) who requested a Medicare demand bill.

Findings included:

R36's medical record reflected the facility issued the Notice of Medicare Provider Non-Coverage and the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 10/28/16. The SNFABN indicated R36 had partially met goals and progress ceased with other goals and the estimated cost per day to continue the services was $234.83 . The notices indicated the last covered day of skilled services was on 11/2/16. Both forms were signed on 11/2/16, by R36's power of attorney (POA). The option to continue to receive services was marked with an "x" on the SNFABN form. The marked option explained, "I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision."

Accounting records reflect Medicaid was billed for dates 11/2/16, through 11/15/16, for the amount of $3406.00.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245307	A. BUILDING: _____ B. WING _____	3/7/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 492	Continued From Page 1 On 3/2/17, at 2:53 p.m. billing worker (BW)-A verified Medicaid was billed while the record was under review. BW-A explained she had thought they could bill Medicaid and just not the resident and stated, "this is the way we do it all the time." Facility Demand Billing Policy dated 6/10/16 included, "Cornerstone Nursing and Rehab Center is prohibited from billing beneficiaries who request a demand bill submission or from collecting money from them prior to a coverage decision made by the intermediary. Charges related to ordinarily non-covered items or services, or co-insurance amounts are an exception. Once the review is completed, the intermediary will notify Cornerstone Nursing and Rehab Center and the beneficiary of the decision."

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 _____	C 03/07/2017

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 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on 2/27/17, through 3/7/16. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess falls and implement interventions in order to minimize the risk of further falls and/or injury and failed to assess for the safe use of a mechanical standing lift in order to ensure a resident was physically capable to utilize the lift safely. This failure resulted in the high potential for harm or death. The facility was notified of the IJ's on 3/2/17, at 12:43 p.m. and on 3/3/17, at 4:50 p.m. An extended survey was conducted by the Minnesota Department of Health on 3/3/17, through 3/7/17. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.	F 156		3/30/17

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

Electronically Signed | 04/01/2017

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

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 _____	C 03/07/2017

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F 156	Continued From page 1 §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and	F 156		

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 _____	C 03/07/2017

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F 156	Continued From page 2 (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud	F 156		

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 156	Continued From page 3 Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning	F 156		

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 156	Continued From page 4 to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	F 156		

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 156	Continued From page 5 (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 156	Continued From page 6 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 2 of 3 residents (R41, R51) with the Notice of Medicare Provider Non-Coverage prior to discontinuation of skilled services, as required. Findings include: R41's Face sheet indicated R41 was admitted to the facility on 11/28/16, and was discharged on 12/16/16. R41's discharge summary dated 12/16/16, indicated R41 was admitted to the facility for physical and occupational therapy after right knee arthroplasty and had met therapy goals. R41's record lacked evidence the Notice of Medicare Provider Non-Coverage was provided. R51's Face sheet indicated R51 was admitted to the facility on 12/2/16, and discharged on 12/16/16.	F 156	Cornerstone Nursing and Rehab Center strives to provide residents with timely notice of Medicare provider non-coverage prior to discontinuation of skilled services. Education and processes have been addressed to assure that this occurs. R41 and R51 were given their Medicare denial notices on 3/23/17 via US postal mail. A late entry was added to resident□s electronic medical chart by the RN in charge. Facility policies and documentation systems were reviewed and updated on 3/30/17 to include giving Medicare denial notices to residents prior to discharge within the necessary time frame. The policy also includes the documenting that the denial notice was given and the rights of the resident to appeal. A Medicare denial log has been initiated for all denials in order to track and monitor compliance on an ongoing basis. This will also provide an audit tool that is ongoing in nature. This log will be brought to weekly discharge planning meetings for observation and initialed by a team	

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F 156	Continued From page 7 R51's Discontinuation of Therapy Services Notification dated 12/12/16, indicated discharge from services date of 12/15/16. R51's discharge summary dated 12/16/16, indicated R51 was admitted to the facility for physical therapy and occupation therapy following a gastrointestinal bleed, frequent falls, and a scalp wound with infection. The discharge summary indicated R51 had met therapy goals. R51's medical record lacked evidence the Notice of Medicare Provider Non-Coverage was provided. On 3/3/17, at 10:54 a.m. billing worker (BW)-A stated R41 and R51 were not given the Medicare denial notice because both R41 and R51 were going home after therapy services ended due to both of them meeting their therapy goals. BW-A stated only residents who stayed in the facility after the end of services, were issued denial notices. BW-A stated R41 and R51 did not initiate the discharge, and had not discharged against medical advice. BW-A stated when residents' were discharged home without a denial notice, the facility did not document or verbally advise them of their right to appeal the discharge. Facility policy Demand Billing Policy dated 6/10/16, indicated: 1. Accounts receivable shall issue the resident	F 156	member present. The Nursing Home Administrator or designee shall review for 3 weeks or until compliance has been reached. The revised policy and procedure will be brought to facility QA meeting on 4/21/17 along with audit results.	

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F 156	Continued From page 8 and/or legal representative a non-coverage notification. 2. The discharge committee consisting of the Director of Nursing, Social Services, Therapy, and Accounts Receivable shall compile resident information which consisted of resident condition, services resident was receiving and a statement as to reasons for believing the stay was non-covered.	F 156		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		4/15/17

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F 225	Continued From page 9 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and/or the State agency (SA) potential abuse/mistreatment for 2 of 3 residents	F 225	Cornerstone Nursing and Rehab Center strives to provide timely reports of alleged violations involving abuse, neglect, exploitation or mistreatment of any	

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F 225	Continued From page 10 (R59, R12) reviewed for potential allegations of abuse. The facility also failed to ensure pre-screening in the form of references checks was performed for 1 of 5 new employees (NA-O) reviewed for abuse prohibition. Findings include: R59's fall with serious injury was not immediately reported to the SA, as required. R59's Resident Progress Note dated 11/26/16, indicated R59 had a fall around 9:00 a.m. He fell to his left side and complained of pain in his left hip area. R59 was assisted to a wheelchair with three staff, transferred to his bed and an ambulance was called due to continued pain in the left hip. R59's Resident Progress Note dated 11/30/16, indicated R59 was admitted to the hospital on 11/26/16, following the diagnosis of a left hip fracture and had surgical repair on 11/27/16. Review of Vulnerable Adult (VA) reports indicated the social service designee (SSD) received a voicemail at home on 11/27/16, which had been left on 11/26/16, regarding R59's fall and subsequent hip fracture. The SSD submitted the report to the SA on 11/28/16, two days after the injury. R12 willfully hit another resident and the staff	F 225	resident to proper authorities. As well as ensure proper pre-screening of employees in the form of references checks is conducted. Education and processes have been addressed to assure this occurs. R59 & R12 VA reports were filed following the incident. Reference checks for employee NA-O were sent 3/15/17, however, only one of the reference checks has been returned as of 3/27/17. The vulnerable adult (VA) policy and procedures was reviewed with all staff. Education was provided to staff on 3/22/17 and 3/23/17 regarding the VA reporting requirements and the definitions of what constitutes a VA incident. All staff will be educated by 4/1/17. Hiring of Applicant for Employment policy and procedures was reviewed with department heads and secretary. Education was provided to secretary on 3/3/17. A VA policy and procedures book with step by step instructions on VA reporting was placed at each nurse□s station. Nurses were trained that they must contact Social Services or Director of Nursing (DON) immediately following an incident. The Social Services designee or the DON will then immediately notify the Nursing Home Administrator. Audits of the progress notes will take place by training each nurse to run an activity report. Each report will be reviewed for potential VA issues and other care related concerns at the start of each shift. A VA screening audit will be completed every shift for 2 weeks, then daily for 2 weeks, then weekly until compliance has been	

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F 225	Continued From page 11 failed to report the incident to the administrator or the SA. R12's Resident Progress Note dated 2/28/17, indicated R12 attacked another resident who was walking down the hallway. R12 wheeled up to the unidentified resident, took a baby doll from that resident and proceeded to hit her with it. There was no documentation of notification to the administrator or report submitted to the SA. Review of VA reports indicated nurses notes from 2/28/17, reviewed by SSD revealed R12 had demonstrated behaviors of aggression toward other residents. No injuries were sustained, but physical contact was made between R12 and another resident. The SSD had not received a report from the night nurse but did file the report due to the physical contact and also notified the administrator. The SSD submitted the report to the SA on 3/2/17, two days later. On 3/2/17, at 6:55 a.m. licensed practical nurse (LPN)-C stated if an incident of potential abuse and neglect occurred, she would notify the registered nurse on call and would not notify the administrator. LPN-C stated she had not been trained how to notify the SA. On 3/2/17, at 7:20 a.m. LPN-A stated if an incident of potential abuse and/or neglect occurred during her shift, she would notify the director of nurses (DON) and would notify the administrator if she thought it was a problem. LPN-A stated she did not have access to the SA	F 225	reached. Director of Nursing or designee shall monitor completed audit sheets as assigned until compliance is achieved. Audit of new hire pre-screenings shall be completed weekly for 3 weeks or until compliance has been reached by the Administrator or designee. The plan of correction and resulting outcome of audits shall be reported to the QA meeting on 4/21/17.	

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F 225	Continued From page 12 website in order to notify the SA of any concerns related to abuse and/or neglect. On 3/2/17 at 7:30 a.m. LPN-B stated she would notify the SSD of any concerns related to abuse and/or neglect as the SSD was the mandated reporter for the facility. LPN-B stated she would then notify the DON of concerns and would only notify the administrator if she was unable to contact the SSD or DON. LPN-B stated she did not have the access to the SA website. On 3/3/17, at 3:31 p.m. the SSD confirmed she had not received notice of R59's fall with fracture, which occurred on 11/26/16, until 11/27/16, and did not report the incident to the SA until 11/28/16. The SSD also verified the resident to resident altercation was not reported by nursing staff and should have been reported to the administrator and SA immediately. The SSD stated they had plans to reeducate staff regarding VA reporting. On 3/3/17, at 3:43 p.m. the administrator confirmed she would expect incidents of potential abuse/mistreatment be reported to the administrator and the SA, as directed by facility policy. The Vulnerable Adult policy dated 11/28/16, indicated a mandated reporter who suspected abuse or neglect of a resident or had reasonable cause to believe a resident had been abused or neglected or had knowledge a resident had sustained an injury not reasonably explained by history of such injury would immediately report	F 225		

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F 225	Continued From page 13 such information to their supervisor. The supervisor in turn would use the chain of command to immediately report any incidents to the director of nursing or social service director and immediately to the administrator and OHFC [Office of Health Facility Complaints]. Nursing assistant (NA)-O was hired by the facility and the facilty failed to perform pre-screening reference checks, as required. A review of NA-O's employment file indicated she was hired at the facility on 1/11/17, however, NA-O's employment file did not contain evidence of a reference check being completed. On 3/3/17, at 9:18 a.m. the facility secretary (SEC) indicated she was responsible for completing reference checks for new employees and stated she usually sent out requests for two references for each individual. The SEC stated when the requests were sent, she made a notation on the application for employment next to the reference contacted, however, verified references were not requested for NA-O. On 3/3/17, at 3:43 p.m. the administrator confirmed she expected references to be checked as directed by the facility policy. The Vulnerable Adult policy dated 11/28/16, indicated screening of new hires would include a complete reference check with past employment and personal references.	F 225		

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F 225	Continued From page 14 The Hiring of Applicant for Employment Policy dated 7/2/12, indicated during the interview, the applicant would sign one or two reference request forms authorizing release of information regarding past employment. The policy indicated these forms would be mailed to the listed past employers by the secretary	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		4/15/17

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F 226	Continued From page 15 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse policy and procedures related to the immediate reporting of potential abuse/mistreatment to the administrator and/or State Agency (SA) for 2 of 3 residents (R59, R12) reviewed for abuse prohibition who had a fall with serious injury or was involved in a resident to resident altercation. In addition, the facilty failed to conduct personal/employment pre-screening reference checks for 1 of 5 new employees (NA-O) Findings include: The facility's Vulnerable Adult policy dated 11/28/16, indicated a mandated reporter who suspected abuse or neglect of a resident or had reasonable cause to believe a resident had been abused or neglected or had knowledge a resident had sustained an injury not reasonably explained by history of such injury would immediately report such information to their supervisor. The supervisor in turn would use the chain of command to immediately report any incidents to the director of nursing or social service director and immediately to the Administrator and OHFC [Office of Health Facility Complaints]. The policy also indicated screening of new hires would include a complete reference check with past employment and personal references.	F 226	Cornerstone Nursing and Rehab Center strives to provide timely reports of alleged violations involving abuse, neglect, exploitation or mistreatment of any resident to proper authorities. As well as ensure proper pre-screening of employees in the form of references checks is conducted. Education and processes have been addressed to assure this occurs. R59 & R12 VA reports were filed following the incident. Reference checks for employee NA-O were sent 3/15/17, however, only one of the reference checks has been returned as of 3/27/17. The vulnerable adult (VA) policy and procedures was reviewed with all staff. Education was provided to staff on 3/22/17 and 3/23/17 regarding the VA reporting requirements and the definitions of what constitutes a VA incident. All staff will be educated by 4/1/17. Hiring of Applicant for Employment policy and procedures was reviewed with department heads and secretary. Education was provided to secretary on 3/3/17. A VA policy and procedures book with step by step instructions on VA reporting was placed at each nurse□s station. Nurses were trained that they must contact Social Services or Director of Nursing (DON) immediately following an	

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F 226	Continued From page 16 The Hiring of Applicant for Employment Policy dated 7/2/12, indicated during the interview, the applicant would sign one or two reference request forms authorizing release of information regarding past employment. The policy indicated these forms would be mailed to the listed past employers by the secretary. R59's fall with serious injury was not immediately reported to the SA, as required. R59's Resident Progress Note dated 11/26/16, indicated R59 had a fall around 9:00 a.m. He fell to his left side and complained of pain in his left hip area. R59 was assisted to a wheelchair with three staff, transferred to his bed and an ambulance was called due to continued pain in the left hip. R59's Resident Progress Note dated 11/30/16, indicated R59 was admitted to the hospital on 11/26/16, following the diagnosis of a left hip fracture and had surgical repair on 11/27/16. Review of Vulnerable Adult (VA) reports indicated the social service designee (SSD) received a voicemail at home on 11/27/16, which had been left on 11/26/16, regarding R59's fall and subsequent hip fracture. The SSD submitted the report to the SA on 11/28/16, two days after the injury.	F 226	incident. The Social Services designee or the DON will then immediately notify the Nursing Home Administrator. Audits of the progress notes will take place by training each nurse to run an activity report. Each report will be reviewed for potential VA issues and other care related concerns at the start of each shift. A VA screening audit will be completed every shift for 2 weeks, then daily for 2 weeks, then weekly until compliance has been reached. Director of Nursing or designee shall monitor completed audit sheets as assigned until compliance is achieved. Audit of new hire pre-screenings shall be completed weekly for 3 weeks or until compliance has been reached by the Administrator or designee. The plan of correction and resulting outcome of audits shall be reported to the QA meeting on 4/21/17.	

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F 226	Continued From page 17 R12 willfully hit another resident and the staff failed to report the incident to the administrator or the SA immediately, as directed. R12's Resident Progress Note dated 2/28/17, indicated R12 attacked another resident who was walking down the hallway. R12 wheeled up to the unidentified resident, took a baby doll from that resident and proceeded to hit her with it. There was no documentation of notification to the administrator or report submitted to the SA. Review of VA reports indicated nurses notes from 2/28/17, reviewed by SSD revealed R12 had demonstrated behaviors of aggression toward other residents. No injuries were sustained, but physical contact was made between R12 and another resident. The SSD had not received a report from the night nurse but did file the report due to the physical contact and also notified the administrator. The SSD submitted the report to the SA on 3/2/17, two days later. On 3/2/17, at 6:55 a.m. licensed practical nurse (LPN)-C stated if an incident of potential abuse and neglect occurred, she would notify the registered nurse on call and would not notify the administrator. LPN-C stated she had not been trained how to notify the SA. On 3/2/17, at 7:20 a.m. LPN-A stated if an incident of potential abuse and/or neglect occurred during her shift, she would notify the director of nurses (DON) and would notify the administrator if she thought it was a problem.	F 226		

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F 226	Continued From page 18 LPN-A stated she did not have access to the SA website in order to notify the SA of any concerns related to abuse and/or neglect. On 3/2/17 at 7:30 a.m. LPN-B stated she would notify the SSD of any concerns related to abuse and/or neglect as the SSD was the mandated reporter for the facility. LPN-B stated she would then notify the DON of concerns and would only notify the administrator if she was unable to contact the SSD or DON. LPN-B stated she did not have the access to the SA website. On 3/3/17, at 3:31 p.m. the SSD confirmed she had not received notice of R59's fall with fracture, which occurred on 11/26/16, until 11/27/16, and did not report the incident to the SA until 11/28/16. The SSD also verified the resident to resident altercation was not reported by nursing staff and should have been reported to the administrator and SA immediately. The SSD stated they had plans to reeducate staff regarding VA reporting. On 3/3/17, at 3:43 p.m. the administrator confirmed she would expect incidents of potential abuse/mistreatment be reported to the administrator and the SA, as directed by facility policy. Nursing assistant (NA)-O was hired by the facility and the facilty failed to perform pre-screening reference checks, as required. A review of NA-O's employment file indicated she	F 226		

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F 226	Continued From page 19 was hired at the facility on 1/11/17, however, NA-O's employment file did not contain evidence of a reference check being completed. On 3/3/17, at 9:18 a.m. the facility secretary (SEC) indicated she was responsible for completing reference checks for new employees and stated she usually sent out requests for two references for each individual. The SEC stated when the requests were sent, she made a notation on the application for employment next to the reference contacted, however, verified references were not requested for NA-O. On 3/3/17, at 3:43 p.m. the administrator confirmed she expected references to be checked as directed by the facility policy.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide personal cares in a manner which promoted privacy and dignity for 1 of 1 resident (R56) in the sample observed to receive the application of ace wraps in a public setting and for 1 of 1 resident (R15) observed to have tube feedings initiated in a public setting.	F 241	Cornerstone Nursing and Rehab Center strives to provide treatment and care of each resident in a manner and in an environment that promotes privacy and dignity. Education and processes have been addressed to assure that this occurs. It is understood that privacy should be	4/15/17

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F 241	Continued From page 20 Findings include: R56 did not receive the application of ace wraps in a private and dignified manner. R56's admission Minimum Data Set (MDS) dated 9/19/16, indicated R56's diagnoses included vascular dementia with behavioral disturbances, macular degeneration and a history of gout. The MDS indicated R56 displayed severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfers and ambulation and was totally dependent on staff for wheelchair mobility on and off of the nursing unit. R56's quarterly MDS dated 12/11/16, also indicated R56 had severe cognitive impairment and required extensive assistance of two staff for all activities of daily living. R56's care plan dated 9/13/16, indicated R56 required medication management due to receiving prescription medications. However, the plan did not address the use of the ace wraps for the treatment of edema. A physicians order dated 2/21/17, directed staff to administer 40 milligrams (mg) of Lasix (diuretic) once a day for five days, then to resume 20 mg. A second order directed staff to apply ace wraps daily [lower bilateral extremities] for the treatment of edema.	F 241	offered to all residents prior to conducting a treatment. R15 and R56 were observed and no negative side effects or impacts were noted. All residents will be offered privacy regardless of cognition during treatment. Resident choices and preferences will be honored and noted on the care plan. Education to staff regarding dignity and respect when providing treatments was provided on 3/22/17 and 3/23/17. Actions rounds shall be implemented and occur daily in an ongoing manner. Action rounds shall include identified survey findings such as providing treatment in public areas. Licensed nursing staff shall audit daily. The Director of Nursing or designee shall review weekly for 3 weeks and quarterly thereafter or until compliance has been reached. The plan of correction and resulting outcome of audits shall be reported to the Quality Assurance Committee meeting on 4/21/17.	

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F 241	Continued From page 21 On 2/28/17, at 8:51 a.m. R56 was observed seated in the 100 unit lobby recliner. R56 was in full visual view of R50, R10, the interim director of nursing (IDON) and registered nurse (RN)-A. Licensed practical nurse (LPN)-D approached R56, removed R56's shoes and socks and proceeded to wrap R56's legs from her toes to her knees with ace wraps. When the wraps were applied, LPN-D reapplied R56's socks and shoes and allowed R56 to remain in the recliner. Throughout the application, R56 remained in full view of R50, R10, the IDON and RN-A. At no time did the IDON or RN-A cue LPN-D to apply the ace wraps in a private area in order to ensure R56's dignity was maintained. On 3/2/17, at 10:30 a.m. LPN-B stated R56's ace wraps were to be applied in the resident's room to ensure privacy and dignity was maintained. On 3/3/17, at 9:48 a.m. RN-A stated R56's ace wraps should have been applied in either R56's room or bathroom. She confirmed the application of ace wraps in the lobby area in front of other residents did not promote R56's dignity. A policy related to resident dignity during while receiving cares was requested and none was provided. R15 required tube feedings and the staff failed to initiate a feeding in a private area to ensure privacy and dignity was maintained. R15's facility face sheet indicated R15 was in a	F 241		

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F 241	Continued From page 22 persistent vegetative state. R15's Care Plan dated December 2016, indicated R15 had impaired cognition and communication, was unable to express wants and needs, was unable to follow directions, remained in vegetative state and was at risk for vulnerability related to those deficits. R15 received nothing by mouth and was dependent on staff for all nutrition an hydration via a G-tube (tube inserted into the stomach) feeding. R15's physician orders indicated tube feeding to run at 85 milliliter (ml) per hour starting at 5:00 a.m. and turned off at 11:00 p.m. each day. On 2/28/17, at 9:33 a.m. nursing assistant (NA)-P was observed to push R15 in his wheelchair into the day room. Seven other residents were present in the day room within full visual view of R15. NA-P proceeded to donne gloves, lift up R15's shirt exposing his abdomen, connected the feeding solution to the G-tube and turned the feeding pump on. On 3/2/17, at 8:14 a.m. R15 was observed seated in his wheelchair, in the day room, with two other residents present. LPN-A disconnected R15's feeding tube then reconnected it. LPN-A washed her hands, donned gloves, lifted up R15's shirt exposing the left side of his abdomen, disconnected the feeding tube, changed the feeding solution bottle, then reconnected the feeding tube.	F 241		

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F 241	Continued From page 23 -At 8:23 a.m. LPN-A stated the reason she performed the procedure in the day room was because it needed to be done and due to R15 being non-communicative, she did not take R15 back to his room to ensure privacy and dignity was maintained. LPN-A stated there was only one other resident in the area when she performed the procedure and she too was not communicative. -At 2:53 p.m. social worker designee (SSD) stated it was not appropriate to provide personal care in the day room. The SSD stated staff should have taken R15 to his room if care involved lifting up his shirt. The SSD stated if residents were not able to communicate, the staff should think of or do what a reasonable person would want. On 3/6/17, at 9:00 a.m. interim director of nursing (IDON) stated all the residents's should have dignity and privacy maintained, regardless of what their cognition level was. Facility policy Resident Rights, undated, indicated employees shall treat all residents with kindness, respect, and dignity. The facility would make every effort to assist each resident in exercising his/her rights to assure the resident was always treated with respect, kindness and dignity.	F 241		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20	F 279		4/15/17

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F 279	Continued From page 24 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 279		

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F 279	Continued From page 25 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care plans, for 1 of 4 residents (R56) for the use of a standing lift, for 1 of 1 resident (R56) experiencing edema In addition, based on observation, interview, and document review, the facility failed to develop a care plan for the use of anticoagulant medication (warfarin) for 1 of 5 residents (R25) whose medication regimens were reviewed. Findings include: R56 utilized a mechanical standing lift which was not identified on the care plan.	F 279	Cornerstone Nursing and Rehab Center strives to maintain a developed and implemented comprehensive person-centered care plan of each resident. This will include measurable objectives and timeframes to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Education and processes have been addressed to assure this occurs. R56, care plan updated to reflect diuretic medications, ace wraps, and use of stand-up lift. Staff educated at mandatory meetings on 3/22/17 and 3/23/17 regarding signs to monitor for resident receiving a diuretic. R25, care plan updated to reflect the use of an anticoagulant. Risks and side effects	

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F 279	Continued From page 26 R56's care plan dated 9/13/16, indicated R56 had impaired mobility related to deconditioned state and dementia. The plan directed the staff to utilize assistive devices such as a walker, wheelchair and gait belt. The staff were directed to assist R56 with bed mobility and transfers with assistance of one to two staff members. The care plan did not direct the staff to utilize a mechanical standing lift. On 2/28/17, at 8:50 a.m. nursing assistant (NA)-N was observed to transfer R56 from a wheelchair to a recliner using a standing lift. On 2/28/17, at 11:12 a.m. NA-N was observed to transfer R56 from a recliner to a wheelchair via a standing lift. On 3/1/17 at 12:18 p.m. NA-A was observed to transfer R56 from a wheelchair onto the toilet via a standing lift. At 12:26 p.m. NA-A transferred R56 from the toilet to bed using the standing lift. On 3/2/17 at 8:50 a.m. NA-D was observed to transfer R56 from a wheelchair to a toilet via a standing lift. -At 8:58 a.m. licensed practical nurse (LPN)-B confirmed R56 was utilizing the standing lift for transfers and stated R56 was to use the standing lift depending upon her abilities to transfer.	F 279	added to care plan. This information also discussed at staff meeting on 3/22/17 and 3/23/17. Systemically staff were educated on risks and side effects of anticoagulants, diuretics, hypnotics/sleep aids. These drug class medications shall be added as a separate concern on care plans. Education sheets created for these classes of medication for all nursing staff to read and signed. Staff also reeducated on the need for monitoring residents for side effects of these medications. As well as the need to immediately report any change of condition to the appropriate person or department. Audits of progress notes will take place by training each licensed nurse to run the facility activity report. Each report will be reviewed for potential events or change of condition issues and other care related concerns at the start of each shift. These report audits will be completed daily for 4 weeks then weekly for 3 weeks or until compliance has been reached. Group sheet/care plan audit sheets were implemented. Charge nurses for each shift have audited one residents care plan against the NA group sheets to ensure accuracy. The Director of Nursing or designee shall monitor audits of activity sheet and group sheet/care plan weekly for 7 weeks or until compliance has been reached. Results of these audits will be reported at the facility Quality Assurance Committee meeting on 4/21/17.	

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F 279	Continued From page 27 On 3/3/17, at 9:25 a.m. the interim director of nurse (IDON), covering in the absence of the director of nurses, confirmed R56's care plan did not address the use of a standing lift and according to the care plan R56 was to be assisted by one to two staff members with transfers. R56 received a daily diuretic and the care plan lacked identification of its use. R56's physician's order dated 2/21/17, directed the staff to administer 40 milligrams (mg) of Lasix (diuretic) once a day for five days, then to resume 20 mg. A second order directed the staff to apply ace wraps [bilateral lower extremities] daily for the treatment of edema. R56's care plan dated 9/13/16, indicated R56 required medication management related to receiving prescription medications. The plan directed the staff to administer medications as prescribed by the physician. However, the plan did not identify R56's diuretic therapy or ace wraps for the treatment of edema. On 2/28/17, at 8:51 a.m. R56 was observed seated in a recliner in the 100 unit lobby area. LPN-D approached R56 and proceeded to remove her shoes and socks and wrap R56's legs from her toes to her knees with ace wraps. Once the ace wraps were applied, LPN-D reapplied R56's socks and shoes.	F 279		

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F 279	Continued From page 28 On 3/6/17, at 1:20 p.m. the IDON confirmed R56's care plan was not developed to include the edema, lasix use or the ace wrap applications. R56 received daily anticoagulant medication which was not identified on the care plan. R25's facility face sheet included diagnosis of right femur fracture, congestive heart failure, hypertension, and paroxysmal atrial fibrillation (an intermittent irregular, often rapid heart rate that commonly causes poor blood flow). R25's fourteen day Minimum Data Set (MDS) dated 2/20/17, indicated R25 received anticoagulation (prevent or reduce coagulation of blood, prolonging the clotting time) medication daily. R25's physician order report from 2/6/17-03/6/17, included an order for warfarin (anticoagulant) 1.25 milligrams (mg) every day for fracture of right femur neck. R25's undated Care Plan lacked identification of the use for anticoagulant medication and monitoring/interventions for the potential adverse reaction related to the medication use. On 3/3/17, at 10:05 a.m. RN-B stated anticoagulation therapy was not typically identified on the care plan and she had never seen it on a care plan before. RN-B stated the reason it would go on the care plan was if there was a risk for	F 279		

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F 279	Continued From page 29 bleeding in conjunction with being at risk for falls, however if they were at a high fall risk then the physician would take them off the medication. On 3/6/17, at 12:32 p.m. R25's right arm showed seven small bruises which ranged from dime to quarter size and were at varying stages of healing. R25's left arm showed five bruises that were dime size or smaller at varying stages of healing. R25 explained she bruised easily, at home protected her arms by wearing long sleeves so the number of bruises were not as many. R25 stated she didn't wear long sleeves at the facilty because the facility was warmer than her house. R25 further explained there was more to bump into at the facility and the doorways were not as big in comparison to the ones at home. On 3/6/17, at 9:03 a.m. the IDON stated R25's care plan should have included the use of the anticoagulant medication. Facility policy Care Plans-Comprehensive not dated indicated the facility developed a comprehensive care plan for each resident which included measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. An interdisciplinary Assessment Team, in coordination with the resident and his/her family or representative, developed and maintained a comprehensive care plan for each resident. The comprehensive care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals and objectives in measurable	F 279		

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F 279	Continued From page 30 outcomes, prevent declines in the resident's functional status and/or functional levels and enhance the optimal functioning of the resident by focusing on a rehabilitative program.	F 279		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the staff provided toileting assistance as directed by the care plan for 1 of 1 resident (R56) who required assistance with incontinence cares; and provided repositioning and incontinence cares as directed by the care plan for 1 of 3 residents (R37) who was dependent upon staff for repositiong and incontinence cares. Lastly, the facilty failed to ensure placement of fall alarms and disable the electronics of an electric recliner as directed by the care plan for 1 of 3 residents (R59) reviewed for falls. Findings include: R56 was not provided assistance with toileting for 3 hours and 50 minutes on the morning of 3/1/17.	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. Education and revisions have been made to assure this is accomplished. R56, care plan was reviewed for incontinence schedules on 3/1/17 and was current. Facility policies and documentation systems were reviewed on 3/6/17 with no changes made. Nursing staff attended a mandatory in-service on 3/22/17 and 3/23/17, which addressed the importance of following care plans and reviewed policies. R37, care plan was reviewed for repositioning and incontinence schedules on 3/2/17 and was current. Facility policies and documentation systems were reviewed on 3/6/17 with no changes	4/15/17

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

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F 282	Continued From page 31 R56's care plan dated 9/13/16, indicated R56 was incontinence of bowel and bladder and directed staff to provide assistance with toileting every two hours. On 3/1/17, from 9:00 a.m. to 12:20 a.m. R56 was continuously observed and was not provided toileting or incontinent cares during this time frame. -At 12:20 a.m. R56 was assisted to transfer to the toilet via a standing lift by nursing assistant (NA)-A. R56 was observed to be incontinent of urine. - At 12:30 a.m. NA-I stated R56 had last been assisted to the toilet at 8:30 a.m. a total of 3 hours and 50 minutes earlier. On 3/3/17, at 10:00 a.m. registered nurse (RN)-A stated R56 was to receive assistance with incontinence cares every two hours as directed by the care plan. R37 was not provided every two hour toileting and repositioning assistance as directed by the care plan. R37's care plan dated 8/15/16, directed the staff to check for incontinence at least every two hours and to assist to the toilet as willing with assistance of 1-2 staff. The plan also identified R37 was at risk for the development of pressure ulcers and directed the staff to repositiong R37 every two hours.	F 282	made. Nursing staff attended a mandatory in-service on 3/22/17 and 3/23/17, which addressed the importance of following care plans and reviewed policies. R59, care plan was reviewed for fall prevention plan regarding fall alarms and recliner being unplugged when resident using it on 3/6/17 and were current. Facility policies and documentation systems were reviewed on 3/6/17, with updates made as necessary. Nursing staff attended a mandatory in-service on 3/22/17 and 3/23/17, to address the importance of following care plans. Fall prevention audit sheets are being used by licensed staff through observations of interventions identified as per resident care plan. Audits are completed 4 times a day at random intervals. Certified nursing assistants are using updated toileting and repositioning tracking sheets to document the frequency for each resident as per care plan. The Director of Nursing or designee shall monitor compliance by conducting weekly audits of the documentation for 3 random residents. This will be ongoing until compliance has been reached. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee meeting on 4/21/17.	

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F 282	Continued From page 32 On 3/2/17, at 8:00 a.m. R37 was observed seated in a wheelchair, in the memory care unit. -At 9:14 a.m. R37 was wheeled to the 100/200 unit for morning activities. -At 9:54 a.m. R37 was returned to the memory care unit. -At 11:00 a.m. R37 remained in her wheelchair. -At 11:08 a.m. the surveyor intervened and requested R37 be assisted with toileting needs. -At 11:17 a.m. NA-B and NA-G assisted R37 out of the wheelchair and ambulated her to her bathroom. A pressure redistribution cushion was observed on the wheelchair. R37 was noted to have been incontinent of urine. R37's skin was pink and intact. Both NA-B and NA-G stated they did not know when the last time R37 had been assisted with incontinence cares or was repositioned. -At 2:50 a.m. NA-D stated R37 had received a bath at 7:30 a.m. and was last assisted with incontinence cares at that time. NA-D confirmed R37 was not assisted with incontinence cares from 7:30 a.m. to 11:17 a.m. a total of 3 hours and 50 minutes. On 3/3/17 at 3:00 p.m. the RN-A stated R37 was to receive assistance with repositiong and incontinence cares every two hours as directed by the care plan. R59 was at risk for falls and the staff failed to ensure fall alarms were in place and the electric recliner was unplugged as directed by the care plan.	F 282		

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F 282	Continued From page 33 R59's Care Plan indicated R59 had a behavior of self-transferring, was forgetful, had confusion with disorganized thinking, had impaired mobility related to left hip fracture, was weight bearing as tolerated, required assist of two staff for transfers, assist of 1 to 2 for ambulation, and assist of two for toileting. The fall care plan indicated R59 had potential for falling related to history of multiple falls, self-transfers even after given risks and benefits for assistance, psychotropic medication, had impaired balance, and impulsivity. The fall interventions included: alarms for bed/wheelchair/recliner, monitor whereabouts, keep in view of staff when up in chair and during waking hours-like recliner in lobby (dated 12/7/16), hourly safety checks on resident and alarms, and disable electric recliner or seat him in a different recliner (dated 12/25/16). R59's undated nursing assistant care guide indicated R59 required standby assist of one staff, used a walker, required alarms in bed and chair, and provide frequent checks. On 2/28/17, at 9:40 a.m. a surveyor found R59 on the floor in his room next to the radiator with the wheelchair near his legs. Safety alarms were not heard. R59 was calling out for help. RN-B alerted to the fall and went immediately to R59's room. A subsequent Nurse Progress note dated 2/28/17, indicated R59 had an unwitnessed fall in his room, was found lying on the floor in front of his wardrobe closet, had a 1.5 inch laceration to the back of his head, R59 stated he could not remember what he was getting up to do, and was sent to the emergency room where seven sutures were needed to close the laceration. The	F 282		

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F 282	Continued From page 34 corresponding event report dated 2/28/17, indicated R59's personal safety fall alarm was not in place. On 3/1/17, at 1:43 p.m. the interim director of nursing (IDON) stated the expectation was for staff to follow the care plan as directed. -At, 3:44 p.m. R59 was observed seated in electric recliner in the lobby. The recliner was plugged in. At this time, the administrator confirmed the chair was plugged in and proceeded to unplug it. -At 3:25 p.m. NA-F stated R59 was supposed to have bed and chair alarms in use. -At 3:30 p.m. NA-G stated R59 was supposed to have chair and bed alarms in place. -At 3:40 p.m. trained medication assistant (TMA)-A stated R59 was supposed to have bed and chair alarms in place. -At 3:50 p.m. LPN-A confirmed R59 was supposed to have bed and chair alarms in place. Facility policy Care Plans-Comprehensive not dated, did not indicate implementation and or following the care plan, however, included indicated the facility developed a comprehensive care plan for each resident which included measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. An interdisciplinary Assessment Team, in coordination with the resident and his/her family or representative, developed and maintained a comprehensive care plan for each resident. The comprehensive care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems,	F 282		

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F 282	Continued From page 35 reflect treatment goals and objectives in measurable outcomes, prevent declines in the resident's functional status and/or functional levels, and enhance the optimal functioning of the resident by focusing on a rehabilitative program.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		4/15/17

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F 309	Continued From page 36 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor edema for 1 of 1 resident (R56) who had an increase in diuretic medication due to increased edema. In addition, the facility failed to identify, assess and monitor impaired skin integrity for 1 of 3 residents (R33) observed to have a non-pressure skin condition without staff identification. Findings include: R56's admission Minimum Data Set (MDS) dated 9/19/16, indicated R56 diagnoses included vascular dementia with behavioral disturbances, hypertension, macular degeneration and a history of gout. R56 had severe cognitive impairment, required extensive assistance of two staff for bed mobility, transfers and ambulation. R56 was totally dependent upon staff for wheelchair mobility on and off of the nursing unit. R56's quarterly MDS dated 12/11/16, also identified R56 had severe cognitive impairment and required extensive assistance of two staff for all activities of daily living. A physicians order dated 2/21/17, directed staff to administer 40 milligrams (mg) of Lasix (diuretic) once a day for five days, then to resume 20 mg. A second order directed staff to apply ace wraps daily for the treatment of edema.	F 309	Cornerstone Nursing and Rehab Center strives to provide the highest quality of care based on comprehensive assessments of a resident that includes treatment and care in accordance with professional standards of practice. Education and revisions have been made to assure this is accomplished. R33, has past history of frequent skin tears, therefore, a daily skin observation has been implemented. Nurses reeducated on events for skin injury. R56, care plan updated to reflect diuretic medications and ace wraps. Staff educated at mandatory meetings on 3/22/17 and 3/23/17 regarding signs to monitor for residents receiving a diuretic. Genera; nursing order to be added to MAR if provider wants an update on condition. Daily weights were added to MAR to monitor significant increase or decrease in weight. Licensed staff will observe edema daily during application and removal of ted hose. Nursing staff were educated on what conditions warrant an event, creating the event, all regarding wound tracking and physician order follow ups at a mandatory in-service on 3/22/17 and 3/23/17. Also reeducating staff on updating care plan when physician orders or events require such. Nursing staff shall add separate order for physician follow ups to the	

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F 309	Continued From page 37 R56's care plan dated 9/13/16, indicated R56 required medication management related to receiving prescription medications. The plan directed the staff to administer medications as prescribed by the physician. However, the plan did not identify R56's diuretic therapy or ace wraps for the treatment of edema. A nursing Progress Note dated 2/21/17, indicated R56 had been evaluated by her primary physician who had ordered R56's Lasix to be increased from 20 milligrams (mg) once a day to 40 mg daily for five days, then to resume 20 mg daily for increased edema (swelling) in her lower extremities. The physician also directed the staff to apply bilateral ace wraps and to report to the physician if the edema in the lower extremities had not improved in five days. Review of R56's progress notes lacked indication of edema prior to 2/21/17, (notes on 2/20/17, and 2/1/17). In addition, the progress notes from 2/21/17, - 3/2/17, lacked follow up documentation related to R56's edema. Review of R56's medical record lacked further documentation related to R56's edema. On 2/28/17, at 8:51 a.m. R56 was observed seated in the 100 unit lobby recliner. Licensed practical nurse (LPN)-D approached R56, removed R56's shoes and socks and proceeded to wrap R56's legs from her toes to her knees with ace wraps. When she had completed the wraps, she reapplied the socks and shoes and	F 309	EMAR. Diuretics shall be added as a separate concern on care plans, along with blood thinners, hypnotics/sleep aides. Education sheets have been created for these classes of medications for all nursing staff to read and sign. Licensed staff educated individually on running a facility activity report at the beginning of every shift looking at new orders/treatments, events, and progress notes. This shall ensure accuracy and reduce the risk of missed adverse effects or medication errors. Audits of the progress notes shall occur by training each licensed nurse to run the facility activity report. Each report shall be reviewed for potential events or change of condition issues and other care related concerns at the start of each shift. These report audits will be completed every shift for 3 weeks, then weekly for 3 weeks and quarterly thereafter until compliance has been achieved. All new physician orders/treatments will use the order processing cheat sheet, staff completing will sign and a second staff will co-sign after assuring all steps were taken and accurate. All audit sheets will be monitored upon completion by licensed staff, and initialed by the Director of Nursing or designee to ensure accuracy and completion for 6 weeks, then quarterly for 6 months or until compliance is maintained. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee meeting on 4/21/17.	

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F 309	Continued From page 38 allowed R56 to remain resting in the recliner. On 3/1/17, at 12:03 p.m. R56 was not observed to have ace wraps on her legs. On 3/2/17, at 9:52 a.m. R56 was observed to not have ace wraps on her legs. Review of the electronic medication administration record (EMAR), indicated R56 had refused the wraps on 3/1 and 3/2/17. On 3/2/17, at 10:30 a.m. LPN-B stated R56 had refused to allow the ace wraps to be applied for the past two days. On 3/2/17, at 3:17 p.m. nursing assistant (NA)-G stated R56's legs had been swollen and she had been complaining about her legs and feet. NA-G stated she had reported the concern to the nursing staff. On 3/3/17, at 9:43 a.m. registered nurse (RN)-A stated she was unaware of the physicians order to increase R56's Lasix or apply ace wraps. The interim director of nurses (IDON) stated she had accompanied the physician on rounds when R56 was noted to have increased edema in her legs, feet and ankles. The order to increase her Lasix and apply ace wraps was received and if no improvement was noted, the nursing staff were to contact the prescriber. When asked if any type of monitoring or follow up assessment had been	F 309		

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F 309	Continued From page 39 completed, the IDON confirmed no further follow up had been completed. A Progress Note dated 3/3/17, at 11:05 a.m. written by RN-A indicated R56's physician had been contacted regarding the edema. A diagnosis of venous insufficiency was received related to increased edema. On 3/6/17, at 1:20 p.m. the IDON indicated R56's primary physician had been contacted regarding the lower leg edema and stated R56's edema was unchanged since the additional Lasix order was received. The IDON stated R56 had two plus pitting edema. She confirmed the care plan had not been developed regarding the edema or the use of Lasix and ace wraps. A policy related to resident edema was requested and none was provide. R33 had a non pressure related shin wound which was not assessed timely. R33's quarterly MDS dated 12/4/16, indicated R33 had severe cognitive impairment and diagnoses which included heart failure, hypertension, malnutrition and dementia without behavioral disturbance. The MDS also indicated R33 required extensive assist of two staff for transfer and toilet use and extensive assist of one staff for bed mobility, dressing and personal hygiene. The MDS further indicated R33 had no ulcers, wounds or other skin problems. R33's Urinary Care Area Assessment (CAA)	F 309		

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dated 6/23/16, indicated R33's skin was intact. The MDS indicated R33 had fragile skin, and wore geri sleeves to protect skin. The CAA also indicated R33's skin was monitored daily with cares and toileting.

On 3/3/17, at 9:57 a.m. R33 was observed seated in a wheelchair in her room, wearing geri sleeves to both arms. A dark red/purple area approximately one inch in diameter was observed slightly to the inner side of her left lower shin. The area was raised and had a blood blister-like appearance. R33 stated she did not know how the area occurred.

R33's progress notes and treatment administration history were reviewed from 2/1/17, to 3/7/17, and the documentation did not reflect identification, assessment or monitoring of the wound.

R33's Care Plan dated 12/16, indicated R33 had impaired mobility and fragile skin and directed staff to monitor skin daily. Changes/concerns with skin were to be reported to nursing/provider. The Care Plan indicated R33 had a history of petechial type marks (pinpoint, round red or purple spots that appear on the skin as a result of bleeding)/bruises and directed staff R33 wore arm protectors on both arms due to fragile skin and to remove R33's shoes when in the recliner to avoid skin tears when crossing legs.

On 3/3/17, at 10:07 a.m. nursing assistant (NA)-I and NA-G were observed to transfer R33 to the commode. NA-I and NA-G guided R33's legs during the transfer to bed and then again to the commode. NA-G confirmed R33 wore geri sleeves and stated she had very thin skin and

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was prone to skin tears. NA-I confirmed R33 received skin tears and bruises to her legs as well which were to be reported to the nurse, if occurred.

On 3/6/17, at 10:21 a.m. NA-C indicated she was the bath aide for the facility and completed a skin check with each resident bath and filled out a form to give to the nurse. NA-C stated R33 had her bath today and she had noted a new Mepilex (antimicrobial foam dressing) to her left leg. NA-C indicated she notified the nurse.

On 3/6/17, at 1:07 p.m. LPN-A stated the cart nurses were responsible to take care of resident skin issues such as bumps, bruises and skin tears. LPN-A stated the NAs were to let them know if there was a skin concern and the bath aid also looked at skin during baths and completed a paper bath observation form. R33's Bathing Performance Observation dated 3/6/17, was reviewed. No skin issues were identified. However, LPN-A stated NA-C had told her R33 had a dressing on her lower leg that was not removed. LPN-A went to R33's room and verified via observation a Mepilex dressing to R33's left lower shin area. LPN-A donned gloves, removed the dressing and reported the area was approximately one inch in diameter and the wound was now open and the wound bed was red. A new Mepilex dressing was applied. LPN-A stated wounds should be tracked on the Medication Administration Record (MAR). LPN-A indicated she had recently returned to work after a leave and was unaware how long R33 had the wound.

On 3/7/17 at 9:46 a.m. LPN-E stated the NAs were to report any skin condition to the charge

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nurse who would then assess the area. LPN-E also stated the bath aid completed a bath observation and indicated any skin issues that needed to be addressed. Next the nurse would assess the area and report it to the registered nurse (RN). The RN would assess further to see if wound care or other treatment was needed. LPN-C also indicated the wound would be logged on their Infection Control Symptom Tracking Log. LPN-C stated she was unaware of any issues with R33's left shin. LPN-C confirmed there was no documentation in R33's medical record or on the Infection Control Symptom Tracking Log of any wounds or skin concerns for R33's left shin

On 3/7/17, at 9:55 a.m. RN-A stated she thought someone had mentioned an old blood blister or an old area on R33's shin. RN-A stated she never had a chance to look at it and did not remember how long it had been there. RN-A stated skin concerns should be documented in their medical record and tracked. At 10:03 a.m. RN-A wheeled R33 from the common area to her room and verified R33 had a Mepilex dressing to her left lower leg. RN-A washed her hands, donned gloves, opened the dressing and confirmed the wound was now open. RN-A stated the area appeared to be approximately one centimeter in diameter and circular. RN-A confirmed the wound was not currently being tracked and should have been reported so it could be monitored, especially since R33 had a history of skin concerns.

The undated Care of Skin Tears-Abrasions and Minor Breaks policy directed staff to record the following information in the resident's medical record: site and description of the wound, date and time discovered, date and time of injury if

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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
F 309	Continued From page 43 known, date and time wound care was given, name and title of individual performing the wound care, information (i.e.. bleeding, size of wound, tissue loss etc.) observed when inspecting the wound, how well the resident tolerated the procedure, any problems or resident complaints related to the procedure, any complications related to the abrasion, refusal of treatment, interventions implemented or modified to prevent additional abrasions, the signature and title of the person recording the data and the date and time recorded. The policy also indicated a Report of Incident/Accident form should be completed when an abrasion is discovered.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident	F 314	Cornerstone Nursing and Rehab Center strives to ensure that a resident who	4/15/17

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F 314	Continued From page 44 identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 1 resident (R37) in the sample identified at risk for pressure ulcers. Findings include: R37's quarterly Minimum Data Set (MDS) dated 2/19/17, indicated R37 was diagnosed with Alzheimer's dementia and anxiety, had severe cognitive impairment, was at risk for the development of pressure ulcers and was always incontinent of bowel and bladder and required extensive assistance of two staff for toileting. R37's significant change MDS dated 10/9/16, also indicated R37 was at risk for the development of pressure ulcer and had a history of a stage two ulcer. R37's Pressure Ulcer Care Area Assessment (CAA) dated 11/19/16, directed the reader to the Urinary CAA dated 11/29/16, which indicated R37 was incontinent of bowel and bladder and required assistance with bed mobility. R37's skin was intact at the time of the assessment. R37's Braden Scale for predication of pressure sore risk dated 8/17/16, indicated was at high risk for the development of pressure ulcers. R37's Tissue Tolerance Test dated 10/11/16, indicated R37 had a history of stage two pressure ulcers on her coccyx and indicated R37 was able	F 314	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 promote healing, prevent infection and prevent new sores from developing. R37, care plan was reviewed for repositioning schedules on 3/2/17 and were current. Facility policies and documentation systems were reviewed on 3/7/17, and found to be current. During staff education on 3/22/17 and 3/23/17, staff were educated on following care plans for toileting and repositioning schedules. Nursing Assistant group sheets were reviewed to ensure the care plan is being followed. Systemically care plans will be created for each resident based on admission and quarterly tissue tolerance test, Braden scale, and continence status. A toileting and repositioning schedule shall be developed based on that data collected, which will reduce the risk of pressure ulcers. Group sheet/care plan audit sheets were implemented. Charge nurses for each shift shall audit one residents care plan against the NA group sheets to ensure accuracy. New toileting and repositioning sheets were created and implemented. Staff was educated on usage during staff meeting on 3/22/17 and 3/23/17. Certified nursing assistants shall document toileting	

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F 314	Continued From page 45 to tolerate an every two hour turning and repositiong schedule as she had showed signs of redness over bony prominence after 3 hours. R37's care plan dated 8/15/16, directed the staff to assist R37 with repositiong every two hours. On 3/2/17, at 8:00 a.m. R37 was observed seated in a wheelchair in the memory care unit. -At 9:14 a.m. R37 was wheeled to the 100/200 unit for morning activities. -At 9:54 a.m. R37 returned to the memory care unit. -At 11:00 a.m. R37 remained in her wheelchair. -At 11:08 a.m. the surveyor intervened and requested R37 be assisted with incontinence cares. -At 11:17 a.m. NA-B and NA-G assisted R37 out of the wheelchair and ambulated her to her bathroom. R37's wheelchair was observed to be equipped with a pressure redistribution cushion. R37's skin was observed to be intact. Both NA-B and NA-G stated they did not know when the last time R37 had been assisted with repositioning. -At 2:50 a.m. NA-D stated R37 had received a bath at 7:30 a.m. and was assisted into the wheelchair at that time. NA-D confirmed R37 was not assisted with repositiong from 7:30 a.m. to 11:17 a.m. a total of 3 hours and 50 minutes. On 3/3/17 at 3:00 p.m. the registered nurse (RN)-A stated R37 was to receive assistance with repositiong every two hours as directed by the care plan.	F 314	and repositioning times on this sheet, in addition to group sheets, as per resident care plan every shift to ensure care plan is followed. Licensed staff will monitor compliance by completing action rounds every shift. Action rounds will include review of real time toileting/repositioning times that are documented on the Nursing Assistant group sheets. All action rounds shall be monitored upon completion by licensed staff, and initialed by the director of nursing or designee to ensure accuracy and completion in an ongoing manner. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee quarterly.	

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F 314	Continued From page 46 The undated Pressure Ulcer/Skin Breakdown Clinical Protocol directed the staff to comprehensively assess each residents risk factors for pressure ulcer development. The protocol did not direct the staff to provide services according to the comprehensive assessment.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 315		4/15/17

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F 315	Continued From page 47 continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 2 of 3 residents (R56, R37) according to their assessed need. Findings include: R56 was not provided assistance with timely incontinence cares for greater than three hours. R56's admission Minimum Data Set (MDS) dated 9/19/16, indicated R56 was diagnosed with vascular dementia, had severe cognitive impairment, dementia with behavioral disturbances, and macular degeneration. The MDS indicated R56 was totally incontinent of bowel and bladder and required extensive assistance of two staff to transfer to the toilet. R56's quarterly MDS dated 12/11/16, also indicated R56 had severe cognitive impairment, was totally incontinent of bowel and bladder and required extensive assistance of two staff for all activities of daily living.	F 315	Cornerstone Nursing and Rehab Center strives to ensure that a resident who enters the facility will receive appropriate treatment and services to prevent urinary tract infections and prevent pressure injuries. Ultimately maintaining current bladder status as well as resident comfort. R56 and R37, care plan was reviewed for toileting schedules on 3/1/17 and 3/2/17 respectfully and were current. Facility policies and documentation systems were reviewed on3/7/17, and found to be current. During staff education on 3/22/17 and 3/23/17, staff were educated on following care plans for toileting schedules. Nursing Assistant group sheets were reviewed to ensure the care plan is followed. Systemically care plans shall be created for each resident based on admission and quarterly review based on MDS bladder and urinary assessments. A toileting schedule will be resident centered based on that data collected, which will ensure timely toileting schedules. Group sheet/care plan audit sheets were implemented. Charge nurses for each shift shall audit one resident care plan	

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F 315	Continued From page 48 R56's Urinary Care Area Assessment (CAA) dated 9/13/16, indicated R56 was incontinent of bowel and bladder. The staff were to assist R56 with toileting needs every two hours and provide assistance with incontinence cares every two hours. R56's Bladder Observation (bladder assessment) dated 9/16/16, indicated R56 displayed incontinence without sensation of loss of urine and was not a candidate for bladder retaining due to severe cognitive impairments. R56's care plan dated 9/13/16, indicated R56 was incontinent of bowel and bladder and directed staff to provide assistance with toileting every 2 hours. On 3/1/17, from 9:00 a.m. to 11:02 a.m. R56 was continuously observed sleeping in a recliner in the memory care lobby. -At 11:02 a.m. nursing assistant (NA)-A and NA-I approached R56 and cued her to wake up. -At 11:05 a.m. the two NAs transferred R56 from the recliner to a wheelchair and wheeled to the memory care dining room. R56 remained in the dining room until 11:50 a.m. at which time she was wheeled back into the lobby area. -At 11:58 a.m. the social service designee (SSD) wheeled R56 from the memory care unit to the beauty shop located outside of the 100/200 wing dining room. -At 12:03 p.m. R56 was wheeled out of the beauty shop and positioned next to the 100/200 nurses station.	F 315	against the Nursing Assistant group sheets to ensure accuracy. New toileting and repositioning sheets were created and implemented. Staff was educated on usage during staff meeting on 3/22/17 and 3/23/17. Certified Nursing Assistants shall document toileting and repositioning times on this sheet, in addition to group sheets, as per resident care plan every shift to ensure care plan is followed. Licensed staff will monitor compliance by completing action rounds every shift. Action rounds will include review of real time toileting/repositioning times that are documented on the Nursing Assistant group sheets. All action rounds will be monitored upon completion by licensed staff, and initialed by the director of nursing or designee to ensure accuracy and completion in an ongoing manner. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee quarterly.	

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F 315	Continued From page 49 -At 12:17 a.m. the State Agency (SA) staff asked NA-A to assist R56 to the rest room. -At 12:20 a.m. R56 was assisted to transfer to the toilet via a standing lift by NA-A. R56 was observed to be incontinent of urine. - At 12:30 a.m. NA-I stated R56 was last assisted to the toilet at 8:30 a.m. a total of 3 hours and 50 minutes earlier. On 3/3/17, at 10:00 a.m. registered nurse (RN)-A stated R56 was to receive assistance with incontinence cares/toileting every two hours as directed by the care plan. R37 did not receive assistance with toileting/ incontinence cares for greater than three hours. R37's quarterly MDS dated 2/19/17, indicated R37 had severe cognitive impairment and diagnoses including Alzheimer's dementia and anxiety. The MDS indicated R37 was always incontinent of bowel and bladder and required extensive assistance of two staff for toileting. R37's significant change MDS dated 10/9/16, also identified R37 as always being incontinent of bowel and bladder. R37's Urinary CAA date 11/27/16, indicated R37 was dependent upon staff for incontinent cares and required assistance with incontinence cares every two hours. R37's Bladder Observation (bladder assessment) dated 10/11/16, indicated R37 experienced	F 315		

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F 315	Continued From page 50	F 315		

incontinence without sensation of urine loss, she was not appropriate for a toileting or retraining program and the staff were to offer the toilet as she was willing and check and change every 2 hours.

R37's care plan dated 8/15/16, directed the staff to check for incontinence at least every two hours and to assist to the toilet as willing with assistance of 1-2 staff.

On 3/2/17, at 8:00 a.m. R37 was observed seated in a wheelchair in the memory care unit.
-At 9:14 a.m. R37 was wheeled to the 100/200 unit for morning activities.
-At 9:54 a.m. R37 returned to the memory care unit. A
-At 11:00 a.m. R37 remained in her wheelchair.
-At 11:08 a.m. the SA staff intervened and requested R37 be assisted with toileting/incontinence cares.
-At 11:17 a.m. NA-B and NA-G assisted R37 out of the wheelchair and ambulated her to her bathroom. R37 was observed to be incontinent of urine. Both NA-B and NA-G stated they did not know when the last time R37 had been assisted with toileting/incontinence cares.

At 2:50 a.m. NA-D stated R37 had received a bath at 7:30 a.m. and was assisted with toileting/incontinence cares at that time. NA-D confirmed R37 was not assisted with incontinence cares from 7:30 a.m. to 11:17 a.m. a total of 3 hours and 50 minutes.

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F 315	Continued From page 51 On 3/3/17 at 3:00 p.m. the RN-A stated R37 was to receive assistance with toileting/incontinence cares every two hours as directed by the care plan. The Urinary Continence and Incontinence - Assessment and Management policy dated 8/2006, indicated if the resident does not respond and does not try to toilet, for those with such sever cognitive impairment that they cannot either point to an object or say their own name, staff will use a "check and change" strategy. The strategy involved checking the residnets' s continence status at regular intervals and using incontinence devices or garment. The primary goals are to maintain dignity and comfort and to protect the skin.	F 315		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		4/15/17

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F 323	Continued From page 52 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility demonstrated a systematic failure to comprehensively assess and effectively implement fall interventions in order to minimize the risk for serious injury or death for 1 of 4 residents (R59) residents who had repeated falls, two of which resulted in serious injury. The facility's systematic failure to comprehensively assess and effectively implement interventions for R59 resulted in IJ for R59. In addition, the facility failed to identify the decline in mobility and assess the subsequent use of a mechanical standing lift for transfers in order to ensure the residents ability to safely utilize the standing lift for 1 of 1 resident (R56) who had a decline in mobility and was observed to be unable to bear own weight when staff utilized a standing lift for transfers resulting in the potential for serious harm, injury, impairment or death. This failure resulted in an immediate jeopardy (IJ) for R56. Findings include: R59's IJ began on 11/26/16, when R59 had fallen and sustained a hip fracture which required surgical repair. The facility failed to	F 323	Cornerstone Nursing and Rehab Center strives to keep residents free from injury. This is met by keeping environment free from hazards, and ensuring each resident receive adequate supervision and assistance devices to prevent accidents. A systematic approach has been established and utilized for resident safety. (R59), the systematic approach that has been utilized consists of an event being completed by the nurse, followed by a post fall observation, a complete comprehensive assessment, updated interdisciplinary care plan that identifies goals and interventions, proper communication of any changes, timely documentation in the residents medical record, and updates made to nursing assistants daily worksheets. A comprehensive assessment was completed by the RN on 3/6/17 to determine all appropriate interventions are in place as outlined in the care plan. The comprehensive assessment includes disciplines from nursing, activities, primary care physician, consulting pharmacist and therapies. Resident was screened by	

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F 323	Continued From page 53 comprehensively assess R59's falls for possible causal factors and implement interventions in order to minimize the risk of further falls and injury. The administrator and interim director of nurses were notified of the IJ on 3/2/17, at 12:43 p.m.. The IJ was removed on 3/6/16, at 2:30 p.m., however, non-compliance remained at a lower scope and severity of level G, which indicated actual harm had occurred on 11/26/16, and on 2/28/17. R56's IJ began on 2/28/17, when R56 was first observed to demonstrate the inability to safely transfer while utilizing a mechanical standing lift which could have resulted in a fall with fracture/injury or a subluxation (partial dislocation) of the shoulders. The facility failed to comprehensively assess a recent decline in condition and ability to transfer, and implemented use of a standing lift which posed a significant risk for injury due to R56's inability to bear weight. The IJ was identified on 3/3/17. The administrator and the interim director of nursing were notified of the IJ on 3/3/17, at 4:50 p.m. and the IJ was removed on 3/7/17, at 1:50 p.m.. R59's face sheet included diagnoses of repeated falls, history of subarachnoid hemorrhage, complex partial seizures, weakness, mild cognitive impairment, diabetes type 2, depressive disorder, osteoarthritis, and benign neoplasm of prostate. R59's admission Minimum Data Set (MDS) dated 10/18/16, indicated R59 did not have cognitive impairment, was independent with bed mobility, required supervision for transfers, limited assistance with ambulation, extensive assistance for toileting, did not have problems with balance,	F 323	therapy 3/1/17 for possible causal factors of the fall. Pt determined no changes in condition and advised to continue with the previous plan. Primary provider was contacted via fax 3/2/17 to notify of the recent falls related to impulsivity and diagnosis of Dementia. Requested that medications and diagnosis list be reviewed for causal factors. In addition, requested a risk benefit statement for the use of oxybutynin and the possibility of orthostatic hypotension related to the use of this medication. Resident was seen in house by physician 2/9/17 with no changes noted. Resident was seen by urology 2/10/17, with the WD note stating patient expresses to me that he is doing better on the oxybutynin with less urgency episodes. He did not really have any significant side effects such as dry mouth, dry eyes or constipation. That being the case, recommend continuation of this medication. Orthostatic blood pressures are checked twice per day and within normal limits. On 3/3/17 the consulting pharmacist was contacted to conduct a medication review to identify any potential side effects that could be contributing to the falls, along with recommendations. Residents primary physician was faxed on 3/5/17 the suggested courses of action per pharmacy review. Residents care plan was updated by the RN on 3/2/17 to reflect goals and interventions necessary. The Nursing Assistant daily sheets were updated 3/2/17 to include all interventions to ensure staff awareness of resident safety needs as per the assessment and care plan. Modifications of interventions	

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F 323	Continued From page 54 did not have functional range of motion impairments, and used a cane/crutch for mobility. In addition, the MDS identified R59 was frequently incontinent of urine, had a fall within thirty days prior to admission to the facility, and did not have a history of a fall with fracture. The Fall and Psychotropic Drug Use Care Area Assessment (CAA) dated 10/18/16, triggered related to diagnosis of depression and received Celexa for depression management. The CAA indicated R59 has dementia, was at risk for falls/injury and side effects/ineffective medication. Self transfers even after educated on risks/benefits. Nursing to attempt to anticipate needs and attempt to place R59 in high traffic areas during waking hours. Nursing to continue to monitor side effects/ineffective mediation such as increased lethargy and changes in mentation. Changes and concerns are reported to his provider and family. See care plan for interventions. R59's Medicare MDS dated 1/27/17, indicated R59 had dementia, required extensive assist of two for transfers and extensive assist of one staff for ambulation, toileting and bed mobility. The MDS further indicated R59 used a walker and wheelchair for mobility, had lower extremity impairment on one side, had impaired balance and was frequently incontinent of urine. R59's undated nursing plan of care indicated R59 had confusion/impaired cognition, partial epileptic seizures, fractured left hip with weight bearing as tolerated, and had a potential for falling related to deconditioned state, worsening mental status, impaired balance, impulsivity, psychotropic	F 323	will be made when necessary. Staff education involving resident interventions and implementation was provided to all staff on duty on 3/2/17 and 3/3/17, and remaining staff on their next scheduled shift to ensure resident safety is maintained. All interventions are posted on inside of resident□s bathroom door to ensure staff awareness of all interventions. Fall policy titled Assessing Falls and their causes was reviewed and updated 3/2/17 for compliance. Updates included procedures for the nurse on duty following a fall, which includes evaluated and assessing the root cause, providing proper first aid as needed, notification of family and physician, appropriate documentation to include the event, and defining the details of the fall in the medical record, implementing all appropriate interventions, care planning and communication of the interventions to all nursing staff. The RN shall complete the post fall assessment within 24 hours of the event. The assessment will identify the causal factors or the fall risk through a root cause analysis, and determine if the interventions that are implemented at the time remain effective and appropriate. The nurse and or physician shall identify basis for specific factors, and observe for any delayed complications. The comprehensive assessment shall be completed quarterly or with any significant change of condition by the RN. Nurses were educated on updated policy for Assessing Falls and Causes. Fall interventional audits have been implemented to ensure proper	

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F 323	Continued From page 55 medication use, and history of falls even after given education on risk and benefits for asking for staff assistance and agreeing to ask for assistance. The plan also indicated R59 had an alteration in behaviors related to self transfers, crawling out of bed, verbal aggression, increased agitation, delusional thinking, physical aggression, resistive to medications, hallucinations and inappropriate statements. The plan indicated R59 required two staff for transfers, assist of one to two staff for ambulation, and R59 utilized a walker and wheelchair for mobility. The plan directed staff to: - monitor R59's whereabouts, -Keep floor free of clutter -Wear proper footwear -Anticipate needs -Provide ongoing cues to use call light for assistance -Keep walker within reach -Invite to an encourage to participate in daily exercise programs -Provide ongoing cues to use walker -Occupational and physical therapy to evaluate -Safety devices grab bar, alarms on bed and chair. (Alarm for recliner chair was handwritten and did not indicate a date of implementation). -10/28/16, remove soiled clothing at night, he leaves them at bedside and trips. Check every two hours at night and assess needs. -11/26/16, check functionality of alarm every shift. Place alarm box out of view. Staff ambulate with walker approach slowly and guide him to walker. -12/7/16, keep in view of staff when up in chair and during waking hours-like recliner in lobby. -12/25/16, hourly checks on resident and check alarms, check the size of gripper socks, disable electric recliner or seat him in different recliner. Assist back to bed, anticipate needs if agitated at	F 323	operationalizing of the care plan. This audit consists of observational assessments by the charge nurse, to ensure all fall interventions are implemented per care plan. Charge nurse then documents a description of actions taken to observe fall interventions as well as any corrections that needed to be made at the time of the audit. These audits shall be completed by charge nurse four times per day, and are ongoing until compliance is achieved and maintained. R56, nursing assessment was completed by RN on 3/3/17 to determine the potential causes contributing to an undetermined period of time nursing staff initiated the utilization of a stand-up lift on resident without formal PT/RN comprehensive assessment. Comprehensive PT/RN assessments completed on 3/3/17 that recommended use of stand-up lift due to weakness, stiffness of right knee, and difficulty in walking. On 3/6/17 resident care plan was reviewed and updated to reflect appropriate use of lift devices. All nursing staff educated on 3/7/17 or next scheduled shift updated policy for using a lift device, including Nursing Assistants notifying nurses of change in condition with resident that affect the use of a lift device. Staff reeducated on 3/22/17 and 3/23/17 on notifying the RN of resident□s condition and use of lift. NA orientation checklist reviewed and found to be complete for education on lift usage. Nursing assistant daily sheets were updated on 3/6/17 to reflect appropriate lift for this resident per therapy care plan.	

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F 323	Continued From page 56 night, hourly safety checks, observe for seizure like behavior. -2/2/17, scheduled toileting at 1:00 a.m., 3:00 a.m., and 5:00 a.m., low bed, and floor mat. -2/28/17, may not be in room alone during waking hours. On 3/1/17 this intervention was crossed out and changed to: may be in bed during walking hours to rest or watch TV with bed in low position with floor mat and alarm. Frequent checks by staff and call light within reach. R59's undated nursing assistant care guide directed staff R59 required stand by assistance of one staff for transfers and activities of daily living. R59 was to utilize a walker, bed and chair alarms, staff to conduct frequent checks, low bed and mats and hourly toileting. A hand written entry indicated R59 could be in bed with alarm and mat for naps and T.V. R59's Fall Risk assessments dated 10/13/16, 12/7/16, and 1/10/17, all indicated R59 was at high risk for falls. However, the assessments failed to comprehensively assess R59's risk for falls to include but not limited to trends/patterns to falls, factors that may be causing the falls, and effectiveness of interventions. R59's medical record revealed between 10/12/16, and 2/28/17, R59 had sustained the following thirteen falls, two of which caused serious injury. 1. Progress note dated 10/28/16, at 4:02 p.m. R59 had a witnessed fall in his room when R59 attempted to self-ambulate to the restroom, his walker got caught up on pants that were tangled around his ankles and when the nurse tried to assist, R59 lost balance and he fell. The note indicated R59 sustained reddened areas on mid	F 323	MDS nurse will be responsible for ensuring appropriate assessments, evaluations, and care plans are up to date with appropriate safety devices. Stand Lift audits have been implemented to ensure proper operationalizing of the care plan. This audit consists of observational assessment by the charge nurse to ensure safe transfer with appropriate assistive device. Charge nurse then documents a description of actions taken to observe safe transfers occur as well as any changes necessary at that time. These audits are completed twice a day, once on the AM and once on PM, and ongoing until compliance is achieved and maintained. A systemic approach has been established and utilized for resident safety. This approach consists of an event completed by nurse, followed by a post fall observation, a complete comprehensive assessment, updated interdisciplinary care plan which identifies goals and interventions, proper communication of any changes, timely documentation in resident□s medical record, and an update to the nursing assistant□s daily worksheets. Fall policies have been reviewed and updated on 3/2/17 for compliance. Licensed nursing staff to run facility activity reports every shift to ensure fall procedures are being followed. Safe patient handling policies have been reviewed and updated on 3/6/17. Biweekly stand up meeting (with therapy, RN, and restorative aide) to discuss resident conditions and if changes	

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F 323	Continued From page 57 upper back and small abrasions to right cheek near ear and lower right back of head. The corresponding electronic event report dated on 10/28/16, at 3:54 a.m. was blank other than the fall time of 3:30 p.m., location, vital signs, the associated progress note, and indicated the physician and family members were not notified until 10/29/16 at 2:45 p.m. -The post fall assessment was not completed until 5 days later on 11/2/16, and identified antidepressant use as a risk medication and lacked a comprehensive analysis of identified causal factors. The assessment indicated the care plan would be updated to include, "staff will remove soiled clothing from room at noc [night] so he does not trip on them." The associated progress note for the assessment dated 11/2/16 at 3:24 p.m. also directed staff to check on the resident every two hours at night and assist him as necessary. A progress note on 11/3/16, at 8:21 p.m. indicated a fax was received from the physician with no new orders. 2. Progress note dated 11/23/16, at 2:55 a.m. indicated R59 had a fall in the bathroom after losing balance attempting to wipe something off the floor. R59 sustained a nickel sized sheering area to left knee, small skin tears to left pinky and left ring fingers, did not use walker, and indicated the bed alarm was underneath the bed, therefor the alarm did not sound. The corresponding event report dated 11/23/16, at 3:07 a.m. indicated the fall occurred at 2:30 a.m., and identified anticonvulsant medication use. The report lacked a comprehensive analysis of the identified causal factors and indicated the care plan was not reviewed. The record did not reflect a comprehensive post fall assessment. -This fall was identified on the Resident Fall Log	F 323	are needed to functional maintenance program. The Director of Nursing or designee shall monitor by completing random audits of fall interventions and care plan review to ensure proper assistive devices are in use, no less than 3 times per week for 3 weeks, and weekly thereafter until compliance has been achieved and maintained. Results of these audits will be reported at the facility QA meeting on 4/21/17.	

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with the intervention to check functionality of alarms every shift, however, the care plan was not updated to reflect this intervention until 11/26/16.

3. Progress note dated 11/24/16, at 3:04 p.m. indicated a nursing assistant (NA) was walking by and noticed R59's dresser drawers were pulled out and bent onto the floor, however, R59 was lying in bed. R59 stated he had rolled out of bed. The record did not indicate functionality of alarms at the time of the incident or if other care plan interventions were in place. The record did not reflect a completed event report or a comprehensive post fall assessment. This incident was also not included on the facility Resident Fall Log.

4. Progress note dated 11/26/16, at 9:55 a.m. indicated R59 had fallen on his left side in the hallway. The fall was unwitnessed, R59 did not have his walker and had pain to the left hip area. R59 was assisted from the floor to his wheelchair by three staff members and assisted into bed. The assessment revealed no internal or external hip rotation. An ambulance was called related to pain and R59 was transferred to the hospital. A corresponding event report was not completed until 11/27/16, at 11:48 a.m. and indicated the time of fall was 9:00 a.m., R59's fall alarms were not sounding, and R59 had sustained a left femoral neck fracture. The event report did not include a comprehensive analysis of identified causal factors, indicated fall interventions were not assessed for effectiveness, and the care plan was not reviewed. The record lacked a comprehensive post fall assessment.
-The Resident Fall Log indicated the only intervention added to the care plan was

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"approach slowly and guide him to walker."
-Progress note dated 11/30/16, indicated R59 was readmitted to the facility following surgical repair of the hip fracture. R59 required one to two staff assistance to pivot transfer.

5. Progress note dated 12/1/16, at 7:48 a.m. read, "Fall: resident was sitting in recliner pushed the button all the way up and fell out of the chair. Resident denies any increased pain."
-The corresponding event report dated 12/1/16, at 1:50 p.m. indicated the fall occurred at 7:50 a.m. in the resident's room. The report lacked identification of possible contributing factors and did not identify current medication use. In addition, the event report indicated the physician or the family members were not notified, the fall interventions were not assessed for effectiveness, and the care plan was not reviewed. The record lacked a comprehensive post fall assessment.
-The Resident Fall Log reflected the fall and indicated the intervention for the care plan was, "disable electric recliner or use non-electric recliner," however, this intervention was not added to the care plan until twenty-four days later on 12/25/16.

6. Progress note dated 12/4/16, reported R59 had two falls. The note indicated at 4:00 a.m. R59 was on the floor mat next to his bed with no injuries and did not remember what he was getting up to do. At 6:00 a.m. R59 was again found on the floor mat kneeling next to the bed after bed alarm sounded. No injuries sustained. The corresponding event report dated 12/4/16, at 6:49 a.m. did not identify risk medications, lacked comprehensive analysis of identified causal factors, indicated physician and family members

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were not notified, the fall interventions were not assessed for effectiveness, and the care plan was not reviewed. The record lacked a comprehensive post fall assessment.
-The Resident Fall Log reflected the incidents and indicated the intervention for the care plan as, "assist back to bed or if agitated get up in view of staff." This intervention was not added to the care plan until three days later on 12/7/16.

7. Progress note dated 12/6/16, at 1:40 p.m. reported R59 was found on the floor in the lobby after attempt to self-transfer from wheelchair to recliner, the fall was not witnessed, wheelchair alarm had sounded, and no injuries. The corresponding event report dated 12/6/16, at 1:39 p.m. indicated the fall occurred at 11:50 a.m., R59 had just finished lunch, was wearing gripper socks, and had slipped during self-transfer into the recliner. The event report was incomplete, did not identify any potential causal factors, fall interventions were not assessed for effectiveness, and the care plan was not reviewed. The record lacked a comprehensive post fall assessment.
-The Resident Fall Log reflected this incident and indicated new intervention for the care plan as, "transfer him to recliner after meals," however, there is no evidence this intervention was added to the care plan.

8. Progress note dated 12/8/16, at 10:00 p.m. indicated R59 was found on the floor in the 200 wing lobby under the Christmas tree, fall alarm sounded, R59 had indicated he was going to make a phone call, the fall was unwitnessed, and no injury was obtained. The corresponding event report dated 12/8/16, at 10:12 p.m. identified anticonvulsant medication use and lacked a

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comprehensive evaluation of identified causative factors, indicated the fall intervention of keeping in view of staff after assessing needs was effective. The report indicated the event would be left open to see if current interventions were effective. The record lacked a comprehensive fall assessment. -The Resident Fall Log reflected the incident and included the care plan intervention of, "hourly safety checks, observe for seizure activity," however, this intervention was not added to the care plan until 12/25/16.

9. Progress note dated 12/17/16, at 3:40 p.m. indicated R59 was found sitting against the wall in the bathroom, R59 stated he had lost balance, leaned back up against the wall and slid down onto his butt, no injury was obtained. The corresponding event report was completed eight days later on 12/25/16, which indicated the fall had occurred at 9:30 a.m., R59 had been in his wheelchair, R59's alarm was not in his wheelchair rather was on the recliner, therefor, the alarm did not sound, and R59 had the wrong size gripper socks on. The report indicated R59 was given the appropriate size gripper socks and an alarm was obtained for the wheelchair (alarm now on wheelchair and recliner). The report identified anticonvulsant medication use and lacked a comprehensive analysis of identified causal factors, and indicated the care plan was not reviewed. The evaluation of interventions summary stated, "hourly safety checks and keeping resident if [sig] view of staff have been effective in preventing/reducing falls. Will close event at this time." The record lacked a comprehensive fall assessment.
-The Resident Fall Log reflected the incident and included the care plan intervention of, "alarm added to wheelchair as left in recliner. Resized

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for gripper socks." The care plan was not updated until 12/25/16, to include the interventions of one-hour safety checks and check size of gripper socks.
-Fall follow-up progress note dated 1/18/17, indicated R59 had a fall on 12/17/16, was placed on one-hour safety checks and kept in view of staff when up in chair, and adding the interventions were effective in reducing/preventing falls for this resident do to his impulsivity.

10. Progress note dated 1/30/17, at 1:21 p.m. reported R59's safety alarm sounded, staff immediately responded, found R59 on the floor after attempt of self-transfer to the bathroom. R59 sustained skin tear to right hand index finger, knuckle, and a scab opened on the left elbow. The corresponding event report dated 1/30/17, at 1:10 p.m. lacked identification of risk medications, indicated the care plan was not reviewed, and family was not notified.
-The comprehensive post fall assessment was completed on 1/31/17, and reflected the information on the event report, however, included intervention of scheduled toileting related to BPH (prostate) with urgency.
-The Resident Fall Log reflected the incident and included care plan interventions of scheduled toileting at 1:00, 3:00, and 5:00 a.m. due to enlarged prostate and falls, however the care plan was not updated with this intervention until 2/2/17. Fall follow-up progress note dated 1/31/17, indicated on 1/28/17, R59 had an unresponsive episode and demonstrated postictal behavior. Note recapped fall from 1/30/17, and indicated a history of BPH with urgency and indicated the toileting schedule would be put into place and the other fall interventions would be

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F 323	Continued From page 63 continued. Fall prevention review note dated 2/2/17 included, "Mat added to care plan for safety." 11. Progress note dated 2/12/17, at 6:23 p.m. indicated R59 was found on the floor in his room between the foot of his bed and the bathroom door by non-nursing staff, safety alarm was in place, and R59 did not sustain any injuries. The record lacked an event report, and a comprehensive fall assessment. This fall was not identified on the Resident Fall Log. 12. Progress note dated 2/21/17, at 1:35 p.m. indicated R59 was found on the floor lying on the floor mat with the wheelchair pulled backwards on top of him, had sustained a small skin tear on right hand, and R59 stated he was going to the restroom and tripped on the chair. The corresponding event report dated 2/21/17, at 1:20 p.m. indicated R59 had been sitting in his wheelchair watching TV, the alarm was not in chair, and the fall had been heard by staff in the room across the hall. The report identified analgesic medication use, lacked a comprehensive analysis of identified causative factors, fall interventions were not assessed for effectiveness, and indicated the care plan was not reviewed. The record lacked a comprehensive post fall assessment. -The Resident Fall Log reflected the incident and indicated staff were re-educated and alarms were re-implemented. 13. On 2/28/17, at 9:40 a.m. surveyor found R59 on the floor in his room next to the radiator with the wheelchair near his legs, safety alarms were not heard. R59 was calling out for help. Surveyor reported observation to registered nurse (RN)-B	F 323		

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F 323	Continued From page 64 who immediately went to R59's room. -Progress note dated 2/28/17, indicated R59 had an unwitnessed fall in his room, was found lying on the floor in front of his wardrobe closet, had a 1.5 inch laceration to the back of his head, R59 stated he could not remember what he was getting up to do, and was sent to the emergency room where seven sutures needed to close the laceration to the head. The corresponding event report dated 2/28/17, indicated the personal safety alarm was not in place, identified analgesic medication use, lacked a comprehensive analysis of identified causative factors, the fall interventions were not assessed for effectiveness, and indicated the fall care plan was not reviewed. -A comprehensive post fall assessment was not completed until 3/2/17. The assessment indicated the care plan was not followed related to placement of safety alarms and as a result of the assessment, the nursing assistant care guide was updated to include all of the fall interventions, the care guide was placed in the R59's closet for easy access, the staff were educated on the fall care plan, and the pharmacist and physician were asked for a medical/medication record review related to the number of falls. According to progress note dated 3/2/17, the physician ordered orthostatic blood pressures twice per day for one week and on 3/3/17, the pharmacist recommended obtaining lab tests and changing the seizure medication. On 3/6/17, the facility completed a comprehensive fall risk assessment which recapped R59's falls, interventions, and causal factors. R59's activities and psychosocial needs were also re-assessed. On 3/1/17, at 9:58 a.m. R59 was observed seated in the recliner in the lobby area with feet raised.	F 323		

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R59 attempted to self-transfer without attempting to alert staff, setting off his chair alarm. Staff immediately responded to the alarm and assisted R59 to the wheelchair using a gait belt. Licensed practical nurse (LPN)-E stated staff were not using the walker for transfers because R59's foot was not moving again. The interim director of nurses (IDON) and LPN-E assisted R59 to the restroom, and R59 required extensive assist from both of the nurses and verbal cues to which R59 responded.

-At 10:33 a.m., R59 was observed seated in his wheelchair in the lobby. Staff members were present. R59 wheeled himself out of the lobby, down the hallway and entered his room. NA-A walked down the hallway, however, did not prompt or return R59 to the supervised lobby area.
-At 10:34 a.m., R59 was in his bathroom with no staff present.
-At 10:38 a.m. NA-A walked down the hallway, looked into R59's room and proceeded to walk past the room. NA-A turned back and entered R59's room. NA-A asked R59 what he was doing, R59 reported he was looking for something to spit in. NA-A assisted R59 then assisted him back to the lobby area.

-At 3:44 p.m. R59 was observed seated in the electric recliner, in the lobby. The recliner was plugged in. The administrator confirmed the chair was plugged in and proceeded to unplug it as directed by the care plan.

R59's current physician orders included the following medications which could potentially increase the risk for falls:
-Ditropan XL (medication used to treat over

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F 323	Continued From page 66 active bladder) 10 mg (milligrams) every evening at 6:00 p.m. - Senna-S (medication used to treat constipation) one tablet twice per day -Keppra 1000 mg (anti-seizure medication) in the morning and 750 mg at bedtime. -Celexa 20 mg (antidepressant medication) in the morning. -Sulfasalazine (medication to treat Rosacea) 1000 mg twice per day R59's medical record did not reflect evidence of a comprehensive pharmacist review of medications for potential causal factors related to falls. On 3/1/17, at 1:43 p.m. surveyors conducted an interview with the administrator, IDON, and RN-A. RN-A stated she was the one responsible for completing post fall assessments and falls reporting. RN-A explained, when a resident fell, the staff were to first ensure the resident was safe, the nurse who responded to the fall was to complete an event report, then she [RN-A] documented the fall on the fall log, completed the post fall follow-up assessment, determined interventions which were then added to the care plan. RN-A indicated she was the only staff person that assessed the falls for all residents and stated the facility did not utilize an interdisciplinary approach to evaluate falls such as through a falls committee, rather, the falls were reported monthly to the interdisciplinary team and again quarterly to the quality assurance committee. RN-A stated a post fall assessment was not completed for the fall incident on 11/23/16, because she was not aware the fall that had occurred because an event report was not generated, and because an event report was not generated, a post fall assessment was not completed. The IDON indicated the intervention	F 323		

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F 323	Continued From page 67 of approaching R59 slowly if he did not have the walker when ambulating was added to the care plan in order to prevent R59 from becoming startled and falling. When asked if an intervention was put into place to help remind R59 to use his walker, the IDON stated nothing was added. RN-A confirmed R59's care plan was not updated after the fall on 12/1/16, and no new intervention were added to the care plan after the fall on 12/4/16, and the floor mat that was mentioned in the report was not added to the care plan until 2/2/17. RN-A stated if the falls were close together she would group the falls together and assess all of them at one time. RN-A stated staff attempted to follow R59's care plan but were not able to provide one to one oversight. RN-A stated the post fall assessments for the five falls in December were all completed at the same time on 12/25/16, however, stated the falls were tracked on the Resident Fall Log with the associated interventions and the interventions were not added to the care plan until after the assessment was completed at that time, on 12/25/16. RN-A indicated a note outlining all the fall interventions was posted on the nursing communication board on 12/25/16. RN-A stated on 1/18/17, she did complete a follow up fall note for the fall that occurred on 12/17/16, and sometimes she had to leave the event open and go back to review and assess if the interventions were working. RN-A confirmed interventions for the fall on 1/30/17, was not added to the care plan until two days later. She stated she was not aware of the fall that had occurred on 2/12/17, because an event report had not been completed. RN-A verified R59's care plan interventions were not implemented correctly for the fall that occurred on 2/21/17.	F 323		

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F 323	Continued From page 68 On 3/1/17, at 3:25 p.m. when asked, NA-E was not able to articulate R59's complete list of fall interventions. On 3/1/17, at 3:27 p.m. LPN-B stated she did not work with R59 on a daily basis and was not able to articulate the complete list of fall interventions. On 3/1/17, at 3:30 p.m. when asked, NA-G was not able to articulate R59's complete list of fall interventions. On 3/1/17, at 3:40 p.m. when asked, trained medication assistant (TMA)-A was not able to articulate the complete list of fall interventions for R59, but did state R59 could be in his room alone because he was alert enough to use the call light and ask for help. On 3/1/17, at 3:50 p.m. when asked, LPN-E was not able to articulate R59's complete list of fall interventions. On 3/1/17, at 4:00 p.m. when asked, NA-A was not able to articulate R59's complete list of fall interventions. On 3/2/17, at 8:44 a.m. R59 stated the reason why he was falling was because he was losing his balance. R59 stated it started happening over the last year and his doctor and the facility did not know why he was losing his balance and falling. R59 indicated he was supposed to walk with somebody, had alarms and a mat. R59 stated he felt like he was able to walk ok, but then he would just lose his balance and never knew when it was going to happen. On 3/2/17, at 12:43 p.m. the administrator, IDON,	F 323		

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F 323	Continued From page 69 and RN-A were informed R59 was determined to be in immediate jeopardy related to the lack of an interdisciplinary comprehensive assessment after falls including R59's fall with injury on 2/28/17, and 11/26/16, due to lack of timely care plan revision and/or implementation of care planned interventions as well as the staff's lack of awareness of the fall interventions. The immediate jeopardy that began on 11/26/16, and identified on 3/2/17, at 12:43 p.m. was removed on 3/6/17, at 2:30 p.m. after the facility implemented a removal plan which included: -Completed an interdisciplinary, comprehensive fall assessment which included involvement from activities, physician, and the pharmacist. -Reviewed and revised the care plan based off of the assessment, and implementation of a completed nursing assistant care guide. -Reviewed and Revised the fall policy and procedure to include nurse responsibilities following a fall. -Staff were educated on R59's fall interventions, reporting falls, and timely completion of comprehensive fall assessments, care plan revision, and implementation of fall interventions. The facility Falls and Fall Risk policy and procedure provided by the facility on 3/1/17, indicated the following: Staff would attempt to define possible causes of a fall within 24 hours. After more than one fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. As part of the initial assessment and based on the preceding assessment, interventions to try to prevent	F 323		

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subsequent falls and to address risk of serious consequences of falling would be identified. The staff will monitor and document the effectiveness of the interventions.

Residents must be assessed in a timely manner for potential causes of falls:

-If a resident has just fallen, or was found on the floor without a witness, nursing staff will record vital signs and evaluate possible injuries.
-Nursing would notify the resident's attending physician and family in an appropriate time frame.
-Nursing would observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall, and will document findings in the medical record.
-Documentation will include any signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness and overall function.
-An incident report must be completed by the nursing supervisor on duty at the time of the fall and submitted to the director of nursing services no later than 24 hours after the fall occurred.
-Identifying causes of a fall or fall risk: within 24 hours of a fall, the nursing staff will begin to try to identify causes of the incident and refer to resident specific evidence including medical history, and known functional impairments.
-Staff would evaluate chains of events or circumstances preceding a recent fall.
-The staff would continue to collect and evaluate information until they either identify the cause of failing or determine that the cause cannot be found.
-The unit manager or DON should consult with the physician or medical director to confirm

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F 323	Continued From page 71 specific causes from among multiple possibilities. Documentation related falls such as the condition in which the resident was found, assessment data, interventions, first aide, or treatment administered, notification of the physician and family as indicated, completion of falls risk assessment and appropriate interventions taken to prevent future falls should be in the resident's medical record. R56's admission MDS dated 9/19/16, indicated R56's diagnoses included dementia with behavioral disturbances, psychotic disorder with delusions and macular degeneration. The MDS also indicated R56 had severe cognitive impairment, required extensive assistance of two staff for bed mobility, transfers and ambulation and required total staff assistance for wheelchair mobility. R56's Falls CAA dated 9/19/16, indicated R56 was at risk for falls due to a history of falls and psychotropic medication use. R56 required assistance of two people for transfers, had difficulty following directions and physical therapy services for strengthening. Changes to be reported to provider. R56's quarterly MDS dated 12/11/16, also indicated R56 had severe cognitive impairment and required extensive assistance of two staff for all activities of daily living. R56's Nursing Plan of Care dated 9/13/16, indicated R56 had severe cognitive loss/dementia, mobility and vision loss and a history of falls. The plan also indicated R56 had inattention and difficulty with directions and staying on task. R56 had impaired mobility related to deconditioned state and dementia. The plan directed staff to utilize assistive devices such as a	F 323		

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F 323	Continued From page 72 walker, wheelchair and gait belt and assist of two staff to transfers. R56 had a history of multiple falls due to dementia and impaired balance and directed staff to monitor R56's whereabouts, to wear proper footwear, staff to anticipate needs, keep walker within reach, invite and encourage to attend daily exercise programs, provide cues to use walker, supervise or monitor walking program, occupational (OT) or physical therapy (PT) evaluations, utilize safety devices such as grab bar and alarm system in bed and chair, and a low bed. The goal was for R56 to walk to all destinations with walker. The care plan did not address the use of a mechanical standing lift. R56's Physical Therapist Progress and Discharge Summary dated 10/4/16, indicated R56 was able to safely complete sit to stand and stand to pivot transfers with minimal staff assistance. On 2/28/17, at 8:50 a.m. R56 was observed in the memory care unit living room, seated in a wheelchair. NA-N approached R56 with a Medcare brand mechanical standing lift. NA-N applied the lift's belt around R56's back and fastened it around her mid-abdomen. NA-N lifted R56's feet and placed them onto the lift's foot platform, attached the belt to the lift's raising mechanism and directed R56 to hold onto the lift's handles and proceeded to raise the lift. As R56 was raised from the wheelchair, the lift's belt slid up and rested tautly in R56's axilla (armpits). R56's back was straight, her knees were bent and her thighs were parallel to the floor as she was not bearing any weight on her legs. Throughout the transfer, R56 was not observed to bear her own weight and was held up in the lift by	F 323		

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F 323	Continued From page 73 the belt in her axilla. NA-N was also not observed to provide any cueing to encourage R56 to use her feet to come to a standing position. On 2/28/16, at 11:12 a.m. R56 was observed resting in a recliner. NA-N approached R56 with the standing lift and proceeded to apply the abdominal lift belt around R56's waist, placed her feet on the foot platform and positioned her legs against the shin support guard. NA-N connected the lift, guided R56 to place her hands on the hand grips and proceeded to raise the lift. As R56 was raised, the lift's belt slid up R56's torso resting in her axilla. R56's back was straight, her knees were bent and her thighs were parallel to the floor as she was not bearing any weight on her legs. Throughout the transfer, R56 was not observed to bear her own weight and was held up in the lift by the belt in her axilla. NA-N was also not observed to provide any cueing to encourage R56 to use her feet to come to a standing position. When in the wheelchair, NA-N stated to R56, "That [standing lift] does not work that well for you." NA-N disconnected the standing lift and wheeled R56 out of the lobby. On 3/1/17, at 11:02 a.m. R56 was observed in the memory care lobby, resting in a recliner. NA-A and NA-I approached R56 and informed her they were going to assist her to into the wheelchair. NA-A placed a gait belt around R56's waist and the two NAs physically transferred R56 from the recliner to the wheelchair. R56 was not able to bear weight during the transfer. Total staff assistance of NA-A and NA-I was required to complete the transfer.	F 323		

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F 323	Continued From page 74 On 3/1/17, at 12:18 p.m. R56 was observed seated in her wheelchair. NA-A approached R56 and wheeled her into her room. Once in the room, NA-A connected R56 to the standing lift and began to transfer her from the wheelchair to the toilet. When raised, the belt slid up, resting in her axilla. R56's back was straight, her knees were bent and her thighs were parallel to the floor as she was not bearing any weight on her legs. Throughout the transfer, R56 was not observed to bear her own weight and was held up in the lift by the belt in her axilla. NA-A was also not observed to provide any cueing to encourage the resident to use her feet to come to a standing position. At 12:25 p.m. NA-A stated R56 had gone "down hill" in the past couple of weeks and was not able to stand up. NA-A stated two weeks ago R56 was able to pivot transfer with assistance of one staff person and did not need to use the standing lift. NA-A proceeded to transfer R56 from the toilet to the bed using the standing lift. When raised, the lift's belt slid up and rested in R56's axilla. Throughout the transfer, R56 was not observed to bear her own weight and was held up in the lift by the belt in her axilla. NA-A was also not observed to provide any cueing to encourage R56 to use her feet to come to a standing position. On 3/2/17, at 8:50 a.m. R56 was observed in the memory care dining room, seated in the wheelchair. NA-D approached R56 and wheeled her to her bathroom. NA-D connected the standing lift to R56 by placing her feet on the foot platform, applying the belt around her abdomen and directing R56 to hold onto the hand grips. As	F 323		

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F 323	Continued From page 75 NA-D began to raise R56 from the wheelchair, R56 was not observed to be able to bear weight on her legs. The belt slid up and rested tautly in her axilla which supported her weight. R56's back was straight, her shins were against the shin support, knees bent and her thighs were parallel to the floor. R56 was transferred onto the toilet. -At 8:57 a.m. NA-D was asked if she had ever requested a nurse to observe R56's ability to transfer with the standing lift, NA-D stated she, herself had not requested anyone to observe R56 utilizing the standing lift. -At 8:58 a.m. LPN-B was requested to observe R56 transfer out of the restroom. LPN-B confirmed at this time, R56 was utilizing the standing lift was to continue to use it, depending upon her abilities. -At 8:59 a.m. NA-D began to transfer R56 with the standing lift with LPN-B observing. When raised, the lift's belt slid up and was resting tautly under her armpits. R56's back was straight, her buttocks and thighs were parallel to the floor and her shins were up against the shin support. R56 was not observed to bear weight on her legs. NA-D assisted to pull up R56's pants up and transferred her from the toilet to the bed. LPN-B confirmed R56 did not bear any of her own weight during the transfer. LPN-B verified R56's weight was supported by her axilla and not her legs during the transfer. LPN-B asked NA-D when and how R56 had begun using the standing lift. NA-D stated she did not know when the lift use had first began. LPN-B asked NA-D if the therapy department was aware of R56's inability to stand, and NA-D stated she did not know.	F 323		

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LPN-B asked R56 if she had pain in her leg to which R56 denied. When LPN-B was asked how she felt R56 was able to utilize the standing lift, LPN-B stated R56 looked like "everybody else" when being transferred with the standing lift.

On 3/2/17, at 11:25 a.m. NA-G wheeled R56 to the 300 wing. NA-G and physical therapist (PT)-A were observed to place a gait belt around R56's waist, position a walker in front of her and the two staff assisted R56 into a standing position using maximum assist. When standing, R56 began to scream out. When asked how she felt, R56 stated, "Oh God, I am not good." R56 ambulated approximately 30 feet with the two staff supporting her upper body weight. NA-G stated R56 had had a decline in physical abilities within the past week. LPN-B who had been seated at the 300 wing-nursing desk, observed R56's difficulty with ambulation and weight bearing and stated she would attempt to get a urinalysis the next morning in order to determine if R56's decline was due to a urinary tract infection.

On 3/2/17, at 3:01 p.m. NA-D stated the use of the standing lift was not new and had been used for a few weeks but could not recall the exact date when the lift was started. When asked who had directed the use of the lift, NA-D stated "someone" recommended the use of the lift but could not recall who. NA-D stated R56 use to be able to pivot transfer, however, had been weak for the past week and was no longer able to stand and bear weight.

On 3/2/17, at 3:06 p.m. RN-B stated she had not

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been made aware R56 was having difficulties with standing and bearing weight. She stated if that was the case, R56 was to be evaluated by the physical therapist. When asked when RN-B had last evaluated R56 for the inability to stand, RN-B stated she would be looking at R56 next week due to her next required Minimum Data Set evaluation and assessments. RN-B stated she had last evaluated R56 in December 2016, during the previous MDS assessment. NA-G entered RN-B's office and stated R56 had been using the standing lift for the past day or two, however, did not know when the lift's use had actually started. RN-B stated she would further evaluate R56 next week when she completed the MDS.

On 3/2/17, at 3:25 p.m. a telephone interview was completed with R56's FM-A. FM-A stated she had been to visit R56 over the past weekend. When she arrived at the facility, R56 was resting in bed so FM-A had requested R56 be transferred out of the bed to visit. FM-A stated the NA entered R56's room with a standing lift which was her first knowledge of a mechanical lift needing to be used for R56. FM-A stated prior to moving into the facility, R56 resided in an assisted living and walked independently with a walker.

On 3/2/17, at 3:44 p.m. the surveyor spoke with the administrator and requested to speak with the IDON regarding R56. The administrator explained the IDON and RN-A were busy reviewing another resident's documentation.

On 3/2/17, at 5:54 p.m. the nursing progress notes indicated due to R56's increase in

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F 323	Continued From page 78 weakness and increased malaise, staff would collect urine and send to the lab for analysis. On 3/3/17, at 9:00 a.m. the IDON stated when R56 was discharged from physical therapy in October 2016, she had required only stand by assist with minimal assistance from staff for transfers and she was able to ambulate 350 feet at that time. The IDON reviewed R56's medical record and confirmed an assessment related to R56's ability to transfer had not been completed since October 2016. The IDON did not know when the staff began utilizing the standing lift. The IDON verified R56's care plan failed to identify R56's use of the standing lift as well as a staff directive to utilize the standing lift for transfers. -At 9:25 a.m. the IDON stated R56 was to be assisted by one to two staff for transfers and verified R56's care plan did not address nor direct the staff to utilize the standing lift for transfers. At 9:43 a.m. the IDON stated she was not aware of when the staff started using the standing lift for R56 and that the nurses should have been notified of R56's need to use the lift because a physical therapy assessment should have been completed at that time in order to evaluate R56's needs. At 9:51 a.m. the IDON confirmed R56 had sustained a decline in her mobility. The IDON stated in order to utilize the standing lift, R56 was required to be able to bear her own weight with her legs and not have her weight supported by her axilla. -At 10:09 a.m. NA-F was interviewed with the IDON and RN-A present. NA-F stated she had transferred R56 using a walker and a gait belt	F 323		

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F 323	Continued From page 79 during morning cares and stated, "She [R56] is not safe. Somebody is going to get hurt." NA-F stated she had utilized the standing lift earlier in the shift to transfer R56 in order to provide incontinent cares, but normally would have transferred R56 with one assist and a walker. NA-F stated she had not been directed to use the standing lift but had utilized it only to be able to safely assist R56 with the incontinent cares. NA-F stated, "I just didn't think she [R56] could do it [pivot transfer] safely." -At 10:11 a.m. RN-A observed while the IDON and NA-F transferred R56 via the standing lift in the 100 unit lobby area. R56 was seated in a wheelchair while the IDON assisted R56's feet onto the foot platform. NA-F connected the lift's belt around R56's waist and cued her to stand and hold onto the hand grips. As the lift was raised, the belt slid up R56's torso to her armpits. R56 held on to the hand grips, she leaned backwards with her knees bent and her thighs were parallel to the floor. Throughout the transfer, R56 was not observed to bear her own weight and was held up in the lift by the belt in her axilla. Following the transfer, the IDON stated she did not see any concerns with R56's ability to safely transfer with the standing lift. However, the IDON stated the facility still required an assessment to be completed and documentation in R56's medical record regarding R56's ability to use the lift. On 3/3/17, at 10:28 a.m. physical therapist (PT)-A confirmed R56 had sustained a decline in her ability to transfer and verified during the transfer on 3/2/17, two staff were required to provide	F 323		

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F 323	Continued From page 80 maximum assistance in order to transfer R56 and in the past, had only required minimal staff assistance to transfer. Review of the facility's Lift Devices policy dated 3/3/14, included directions regarding the use of a full body mechanical lift. The policy did not address the use of a standing lift. Review of MedCare Products Operations Manual for Care Stands dated 10/6/16, found on the company website at www.medcarelifts.com and a copy provided by the facility indicated the following: Assessment: The MedCare Stand was designed specifically for assisting patients to a standing position. Because the stand is an assistive device, it should only be used with patients that can bear the requisite amount of weight as determined by the facility. It also requires residents' to possess more advanced motor skills than for the full body mechanical lift. It is important to first determine the appropriateness of this piece of equipment for a particular patient. If you need help in assessing a resident's weight bearing ability, please ask your therapy department for assistance. Care Stand Operations: Belt features: 1. This belt offers support for residents capable of standing upright. 2. Position the belt around the resident's lower	F 323		

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back, just above the belt line. Fasten the buckle to secure belt.
Tip: An assessment of each resident's ability to bear weight should be performed prior to using the Care Stand. If you need help in assessing a patient's/resident's weight bearing ability, please ask your therapy department for assistance.

The Belt Sizing guide section directed the owner to use the sizing chart as a general guide and to keep in mind that residents' that were the same weight may have different body types, shapes and sizes, and may require different sized belts. The guide referenced small-medium-large-X large sized belts which were colored coded for use.

On 3/3/17, at 1:37 p.m. the MedCare company representative was interviewed via telephone. The representative was asked if the operation manual found on the company website would be the appropriate manual for the use of the facility's Model 400002. The representative stated the manual was for an updated model, however the same manual would be appropriate for operational use of the model 400002. The representative stated the only difference in the models would be the actuator would be able to hold more weight on the later models.

On 3/3/17, at 4:47 p.m. the administrator, IDON and RN-A were informed R56 was determined to be in immediate jeopardy related to unsafe transfers while in a standing lift due to R56's inability to bear weight and assist with the transfers.

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F 323	Continued From page 82 A progress note dated 3/3/17, at 6:48 p.m. indicated although R56 had not had any incidents involving the standing lift and falls, the Department of Health would like therapy to evaluate for possible risk of falls with the use of the standing lift. Message left with therapist that staff would be transferring R56 with assist of two staff and a gait belt over the weekend until therapy could evaluate the safe use of the lift. The weekend RN had been updated to observe that staff do not use the standing lift but instead use two staff assist and gait belt to transfer R56. On 3/4/17, at approximately 10:15 a.m. the administrator stated that morning, three staff attempted to transfer R56 from bed. The administrator stated R56 was not able to bear any weight, therefore the standing lift had to be used for resident safety. However, following the conversation, it was confirmed that a standing lift was not used to complete the transfer, rather a full body mechanical lift was used due to R56's inability to bear any weight. On 3/4/17, at 10:40 a.m. NA-A stated prior to today, R56 had been transferred via the standing lift because she was "dead weight." NA-A stated about two weeks ago, she had asked the nurse if physical therapy could evaluate R56 due to her decline in transferring but was unaware if this had happened. NA-A stated that morning, staff had been given the directive to pivot transfer R56 with three staff assist. NA-A stated the transfer did not go well due to R56 not being able to bear weight so the full body mechanical lift had and was to be used for transfers.	F 323		

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A progress note dated 3/4/17, at 3:50 p.m. indicated R56 had experienced difficulty transferring from the toilet to her wheelchair even with step by step instructions as to what to do. R56 displayed confusion, held onto the bathroom bar and would not let go. R56 became physical with staff. The RN determined it was safe to utilize the full body mechanical lift for R56's transfers. A 3/5/17, at 3:07 p.m. a progress note indicated R56 had been transferred via a full body mechanical lift.

The immediate jeopardy that began on 2/28/17, and identified on 3/3/17, at 4:50 p.m. was removed on 3/7/17, at 1:50 p.m. after the facility implemented a removal plan.

The plan included:

- Completed a comprehensive transfer assessment for R56.
- Physical therapy and occupational therapy completed comprehensive evaluations for R56.
- Updated the care plan to direct the care staff as to how to safely transfer R56 dependent upon her cognitive and physical levels.
- Developed and implemented a policy and procedure regarding the safe handling of residents while in a standing lift.
- Staff were educated on the changes to the standing lift policy and changes to R56's care plan.

R56 did not receive comprehensive assessments

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F 323	Continued From page 84 following falls. R56's admission MDS dated 9/19/16, indicated R56's diagnoses included dementia with behavioral disturbances, psychotic disorder with delusions and macular degeneration. The MDS also indicated R56 had severe cognitive impairment, required extensive assistance of two staff for bed mobility, transfers and ambulation and required total staff assistance for wheelchair mobility. R56's Falls Care Area Assessment (CAA) dated 9/19/16, indicated R56 was at risk for falls due to a history of falls and psychotropic medication use. R56 required assistance of two people for transfers, had difficulty following directions and physical therapy services for strengthening. R56's quarterly MDS dated 12/11/16, also indicated R56 had severe cognitive impairment and required extensive assistance of two staff for all activities of daily living. R56's undated Nursing Plan of Care indicated R56 had dementia, inattention, difficulty with directions and staying on task. R56 had a potential for falls related to a history of falls, dementia and impaired balance and directed staff to monitor R56's whereabouts, keep floor free of clutter, to wear appropriate foot wear, provide ongoing cues to use call light for assistance, keep walker within reach, invite and encourage to attend daily exercise programs, provide ongoing cues to use walker, supervise and monitor walking program, PT/OT evaluations, safety devices, grab bar, bed and chair alarm and low bed, An Event Report dated 10/13/16, at 3:11 p.m. indicated R56 was found seated on the floor next	F 323		

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to her bed leaning to the right. R56 appeared to have attempted to self transfer and slid to the floor. R56 had a slightly reddened area on the right side of her back and did not appear to have any further injury. A new bed alarm was placed on the bed as the current alarm had been identified as "slow to respond." The event report indicated the RN-A reviewed this fall event on 10/20/16, (seven days later). A Post Fall Observation report dated 10/20/16, completed by RN-A indicated R56 had been attempting to self transfer, the bed alarm was slow to respond so the staff changed the alarm. No further evaluation of the fall and no new interventions were implemented at the time of the RN assessment.

An Event Report dated 12/21/16, at 2:45 a.m. indicated R56 was found on the floor next to her bed with the bed alarm sounding. R56 was wrapped in her bedspread and was lying on her stomach on a floor mat. No injuries sustained. No further interventions were implemented. On 1/2/17, at 11:43 p.m. (12 days later) RN-A reviewed the incident and indicated there was not pattern to her falls. R56 had advanced dementia and blankets were wrapped around her. RN-A indicated the current fall prevention interventions included the use of a low bed, a fall mat, and a bed alarm. No further analysis of the fall was identified in R56's medical record.

An Event Report dated 1/21/17, at 12:30 a.m. indicated R56 was found on the floor, in her room. The fall mat was in place and the bed alarm was not sounding as the battery was dead. R56 stated she was attempting to go the restroom. No injures were noted. Twelve days later on 2/2/17, at 1:55 p.m. LPN-E completed

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F 323	Continued From page 86 and closed the Event Report. No further assessment or RN analysis of R56's fall was not in the medical record. On 3/3/17, at 9:12 a.m. R56's falls were reviewed with the IDON and RN-A. RN-A stated she had been reviewing R56's medical record on 2/1/17, and discovered that R56 had sustained a fall on 1/21/17, which she was not aware of. The IDON indicated an Event Report was not completed at the time of the fall therefore, further evaluations and RN assessments were not completed. RN-A stated when she discovered this fall, LPN-E was directed to complete the Event Report, as required. RN-A stated LPN-E completed the Event Report along with the post fall assessment therefore, RN-A was not alerted to evaluate this fall occurrence. RN-A indicated she had realized the assessment had not been completed on 3/2/17, so she completed a note at that time. The Post Fall assessment dated 3/2/17, did not identify any additional interventions to be implemented in an attempt to minimize the risk of falls.	F 323		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% affecting 2 of 6 residents (R35, R15) whose medication	F 332	Cornerstone Nursing and Rehab Center strives to ensure that a resident who enters the facility will free of medication error rates of 5% or more. The	4/15/17

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F 332	Continued From page 87 administration was observed. The facility medication error rate was 8%. Findings include: R35's Physician Order Report dated 2/6/17 to 3/6/17, included an order for Immodium A-D (loperamide) 2 mg. Give 2 tabs to equal 4 mg after each loose stool as needed for diarrhea. Do not exceed 16 mg in a 24 hour period. The order start date was 9/16/16. On 3/3/17, at 2:25 p.m. licensed practical nurse (LPN)-D dispensed one 2 milligram (mg) tablet of loperamide from a stock bottle into a medication cup, entered R35's room and administered the medication orally to R35. --At 2:33 p.m. LPN-D stated she only gave 1 loperamide tablet to equal 2 mg to R35 as she had given 4 mg previously that day. On 3/3/17, at 3:06 p.m. LPN-D stated she used the manufacturer's direction on the bottle of medication which directed 4 mg for the first loose stool and 2 mg for additional doses. LPN-D confirmed the order should be 4 mg after each loose stool. LPN-D stated she thought the order had been changed and she missed it. On 3/6/17, at 3:32 p.m. the director of nursing (DON) confirmed the incorrect dose of loperamide had been given and she would have expected R35 be given 4 mg as ordered.	F 332	expectation is that physician orders will be transcribed accurately and followed correctly. Also that nurses shall follow the medication 5 rights prior to administering medications to residents. R35, physician orders were verified and ensured they were transcribed correct in the EMAR. R15, rubber stoppers and syringes were acquired from pharmacy to ensure correct dose will be drawn up from bottle of liquid medication. Staff were educated at staff meeting on 3/22/17 and 3/23/17 on using physician orders versus facility standing orders. The physician will determine dosage as this may differ from facility standing orders or manufacturers recommended dosing. If there is no specific physician order, then standing orders may be implemented. During the staff meeting, education was given on using syringes to drawn up liquid medication, especially if dosage is different than what the graduated medication cups are marked. Administering Oral Medications policy was reviewed and found to be current. The Director of Nursing or designee shall monitor compliance by completing random med pass audits no less than 3 times per week for 3 weeks, then weekly or until compliance has been achieved and maintained. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee meeting on 4/21/17.	

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The undated Administering Oral Medications policy directed staff to verify there was a physician's medication order and confirm the medication name and dose with the MAR [medication administration record] prior to administration of the medication.

R15's Physician Order Report dated 2/6/17, included an order dated 5/6/15, for ferrous sulfate 220 milligrams (mg) (44 mg iron per 5 milliliters (ml). R15 was to receive 7.4 ml of medication every 12 hours via gastrostomy tube.

On 3/2/17, at 9:23 a.m. LPN-A was observed to prepare medication for R15. Included in the medication was ferrous sulfate 220 milligrams of which R15 was to receive 7.4 ml. LPN-A was observed to open the bottle of ferrous sulfate and pour the liquid medication into a graduated plastic medication cup. The medication cup revealed 10 ml of medication. When LPN-A had finished dishing the rest of R15's medications she started gathering the medications to enter R15's room. At this point LPN-A was asked to recheck the ferrous sulfate. LPN-A confirmed the medication cup contained more ferrous sulfate than was order for R15. LPN-A stated the facility had utilized syringes in the past to dispense the medication, but an unidentified nurse had decided that they could "eye ball" the amount. LPN-A explained the plastic medication cups had graduated numbers along the edge of 5 cubic centimeters (cc), 7.5 cc and 10 cc. She stated she usually tried to dispense the medication just below the 7.5 cc mark. LPN-A then poured a small amount of the medication out and stated,

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F 332	Continued From page 89 "that's about as good as I can get." At 9:27 a.m. LPN-A left the medication cart and obtained a syringe. LPN-A drew up the ferrous sulfate from the plastic medication cup and reported that the syringe contained 6 cc of medication. LPN-A then utilized the syringe to dispense 7.4 cc of ferrous sulfate. LPN-A was then observed to administer R15's medication via a gastrostomy tube. On 3/6/17, at 1:05 p.m. registered nurse (RN)-A stated she would expect the nursing staff to draw up 7.4 cc of liquid medication with a syringe. She stated the plastic graduated medication cups identified 7.5 cc and the staff would not be able to accurately draw up 7.4 cc without a syringe. The undated Administering Oral Medications policy directed the staff to administer the proper dose of the medication.	F 332		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		4/15/17

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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
F 334	Continued From page 90 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		

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	245307	A. BUILDING _____ B. WING _____	C 03/07/2017

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F 334	Continued From page 91 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal immunizations were administered or refusal or contraindications to immunizations were documented for 3 of 5 residents (R24, R25, R4) reviewed for immunizations. Findings include: The Center for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccines include: one dose of pneumococcal conjugate vaccine (PCV13) is recommended for all adults aged 65 or older who have not previously received the vaccine. A dose of pneumococcal polysaccharide vaccine 23 (PPSV23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23	F 334	Cornerstone Nursing and Rehab Center strives to ensure that a resident is up to date as per resident wishes on all vaccinations upon admission to facility. Once a resident of the facility, Cornerstone Nursing and Rehab Center strives to continue offering vaccinations and administrating them per facility policy and residents consent to receive vaccinations. R4, R24, and R25 have been given Prevnar 13 vaccine either at Sanford Clinic or at facility after consent was received from either resident or guardian. Pneumococcal Vaccine policy was reviewed and found current. It is the expectation that we obtain immunization records prior to or upon admission. If pneumococcal is due, facility shall request that they give vaccine or give documentation of refusal. If not updated by admission, facility shall administer per policy.	

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F 334	Continued From page 92 R24's admission Minimum Data Set (MDS) dated 12/30/16, indicated R24 had not received the influenza vaccine in the facility as she had previously received it outside the facility. However, the MDS did not address R24's pneumococcal vaccine status. The MDS indicated R24's age was 86. R24's medical record lacked documented evidence PCV13 or PPSV23 had been offered or administered. R25's Minnesota Immunization Information Connection history indicated R25 received PPSV23 on 3/10/10, at the age of 82. R25's medical record lacked documented evidence the PCV13 had been offered or administered. R4's Minnesota Immunization Information Connection history indicted R4 received PPSV23 on 11/4/07, at the age of 71. R4's medical record lacked documented evidence the PCV13 had been offered or administered. On 3/6/17, at 2:52 p.m. registered nurse (RN)-A confirmed R24, R25 and R4 had not been offered or administered the necessary pneumococcal immunizations as per the CDC guidelines. On 3/6/17, at 3:21 p.m. the administrator stated she would have expected residents to be immunized per the facility policy. The Pneumococcal Vaccine policy dated	F 334	The Director of Nursing or designee shall monitor compliance by completing weekly random audits of immunization records of new admissions until compliance has been achieved and maintained. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance Committee meeting on 4/21/17.	

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F 334	Continued From page 93 11/28/16, indicated administration of the pneumococcal vaccination or revaccination's would be made in accordance with current CDC recommendations at the time of the vaccination.	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 356		4/15/17

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F 356	Continued From page 94 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the total number and the actual hours worked for nursing staff directly responsible for resident care per shift. In addition, the hours were not observed posted in a prominent place readily accessible to residents and visitors. This had the potential to effect 42 of 42 residents, staff and visitors. Findings include: During the initial tour of the facility on 2/27/17, at 6:25 p.m. the state agency (SA) staff were unable to locate a posting related to the facility staffing pattern. At 6:45 p.m. trained medication assistant (TMA)-A stated she was unaware of a publicly posted staffing patterns.	F 356	Cornerstone Nursing and Rehab Center strives to ensure that direct care nursing staff shift hours are posted by total number and actual number of hours worked. This information will be accessible to the public. During nursing meeting on 3/22/17 and 3/23/17 staff educated on the necessity of updating information in real time. Policy reviewed and updated 3/16/17 to reflect these requirements. This information is located in a prominent place that is readily accessible to residents and visitors. The Director of Nursing or designee shall monitor compliance by completing audits for the nursing hours posting, no less than 3 times per week for 3 weeks, then weekly until compliance has been achieved and maintained. The plan of correction and resulting outcome of audits will be reported to the Quality Assurance	

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F 356	Continued From page 95 At 6:50 p.m. the administrator was asked where the posting was located. The administrator located a clip board in a dark brown plastic wall folder hanging outside of the door to the receptionist area. She indicated the clip board was to be hanging on the wall, however, the nail had fallen out of the wall and it was not located in the file folder. The file folder contained a three ring binder which held the SA previous year survey and behind the binder was a clip board with the forms identified as "Cornerstone Nursing and Rehab Center Employee Census." The reports identified the date and the resident census. The form also identified registered nurses, licensed practical nurses and nursing assistants (RN, LPN, NA) were identified for each shift, the hours of the shift, the total hours worked. The nursing hours were typed in as to how many nurses were to be on duty for the day and evening shift along with the total number of nursing assistants (NA) were to be on the night shift. However, the total number of registered nurses and the total number of NAs for the day and evening shifts were blank. At 7:25 p.m. the administrator stated the number of RN, and NAs for the day and evening shift were to be completed by the nursing staff. She confirmed the posting for 2/28/17, had not been completed. On 2/28/17, at 3:50 p.m. the administrator provided the SA with staff postings from 2/13/17 - 2/28/17. Review of the posted reports indicated the staff had routinely dated the forms and	F 356	Committee meeting on 4/21/17.	

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F 356	Continued From page 96 identified the current resident census. However, the total of staff providing care had been left blank for each day. The administrator confirmed the posting had not been completed appropriately. She stated she had not been made aware the posting had not been completed. The undated Posting Direct Care Daily Staffing policy directed the shift supervisor to complete the posting within 2 hours of the beginning of each shift by identifying the number of RN, LPN and NAs who were working the shift and who were directly responsible for resident care. The policy also directed the posting to be located in a prominent location that would be accessible to residents, staff and visitors in a clear understandable format.	F 356		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		4/15/17

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F 441	Continued From page 97 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 98 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure community glucometers were disinfected appropriately for 2 of 2 residents (R45, R72) observed to receive glucose testing. This practice had the potential to affect 14 of 14 residents (R45, R70, R8, R3, R36, R42, R40, R49, R35, R69, R30, R24 R72, R73) who utilized the community glucometers. In addition, the facility failed to provide appropriate handwashing while providing direct resident care for 1 of 5 resident (R37) observed receiving cares. Findings include: Glucometer disinfection. R45's Physician Order dated 10/5/16, directed the staff to monitor R45's blood sugar (glucose level) four times a day. On 2/28/17, at 10:58 a.m. licensed practical nurse (LPN)-D was observed to remove a community glucometer from the medication cart and approached R45. LPN-D completed the glucose monitoring by placing a small amount of R45's blood onto a testing strip in the machine. When LPN-D had completed the test, she returned to the medication cart. At 11:06 a.m. LPN-D was observed to open a alcohol swab and wiped the	F 441	Cornerstone Nursing and Rehab Center strives to ensure that residents are not put at risk for transmission of infections. Cornerstone Nursing and Rehab Center strives to maintain proper hand hygiene of its employees to decrease risk of the spread of infections. R45 & R72, facility implemented a personal glucometer for each resident to reduce the risk of transmission of blood borne pathogens, per facility policy. Manufacturer guidelines reviewed. Facility shall implement manufacture recommendations for cleaning by keeping a copy of the User Instruction Manual in each medication cart. Glucometers will be marked with resident name and stored in medication cart. As new residents enter facility they will also be given individual glucometers. Handwashing/Hand Hygiene policy was reviewed and found to be current. Staff were educated on 3/22/17 and 3/23/17 regarding glucometer changes also reeducated on importance of proper hand hygiene (R37). The charge nurse shall monitor compliance by completing action rounds, which include observation of proper hand hygiene every shift in an ongoing manner.	

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F 441	Continued From page 99 outside of the glucometer with the alcohol swab. LPN-D stated the glucometer was utilized for patients residing on the 100, 300 and 400 units of the facility. She confirmed she had used an alcohol wipe to clean the machine. LPN-D the removed a bottle of hydrogen peroxide germicidal wipes from the bottom drawer of the medication cart. LPN-D stated the wipes were used for cleaning the medication carts, but she had not been instructed to use the germicidal wipes to clean/disinfect the glucometers. R72's Physicians Order dated 2/24/17, directed the staff to monitor R72's glucose level twice a day. On 3/2/17, at 6:50 a.m. LPN-A was observed to remove a glucometer out of the 200 unit medication cart. LPN-A was observed to clean the glucometer with an alcohol wipe and then entered R72's room. When LPN-A had completed the test, she returned to the medication cart and wiped the glucometer off with an alcohol wipe and returned it to the medication cart. On 3/2/17, at 10:20 a.m. LPN-B was observed on the 400 unit. LPN-B removed the glucometer from the medication cart and wiped it down with an alcohol wipe. LPN-B then entered R45's room and was observed to check R45's blood glucose level. Upon completion of the glucose monitoring, LPN-B returned to the medication cart, wiped the machine off with an alcohol swab and returned it to the medication cart. LPN-B stated at one time, all of the residents who required blood glucose monitoring had their own	F 441	All action rounds will be monitored upon completion by licensed staff, and initialed by the Director of Nursing or designee, to ensure accuracy and completion in an ongoing manner. The Director of Nursing or designee shall monitor compliance by completing random med. pass audits to observe proper cleaning/disinfecting of glucometers. This will be performed no less than 3 times per week for 3 weeks, then weekly until compliance has been achieved and maintained. The plan of corrections and resulting outcome of audits will be reported to the Quality Assurance Committee quarterly.	

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F 441	Continued From page 100 machines, however, this had been changed so each medication cart had their own machine. LPN-B stated she did not know why the facility had changed. She confirmed the glucometers were to be cleansed/disinfected with an alcohol wipe after each use. On 3/2/17, at 10:54 a.m. the interim director of nurses (IDON), covering in the absence of the director of nurses, stated the staff members were to clean/disinfect the glucometers with alcohol in between each use. She stated last October 2016, each of the residents who required glucose monitoring had their own machines. However, this had changed so each medication cart had a machine which was used on several residents. She stated the nursing staff were to clean/disinfect the machines with alcohol after each use. However, alcohol will not provide sufficient disinfection to protect from blood borne pathogens such as hepatitis or HIV. On 3/6/17, at 1:30 p.m. the IDON reported at one time, each of the residents requiring blood glucose monitoring had their own glucometers. However, the manufacturer of the machines provided by the facility had stopped making the testing trips. A representative had visited the facility and provided three glucometers to the facility until additional glucometers could be ordered. The IDON stated she did not know where the communication breakdown had occurred but after the conversation on 3/2/17, she had located a supply of glucometers in the storage unit and all 14 residents who required glucometers had been provided their own individual glucometer.	F 441		

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The manufacturer's care guide for the glucometers was requested and not provided.

The undated Procedures for Proper Glucometer Use, directed the facility staff to assign a glucometer to each person who required glucose monitoring. The policy also stated if multiple patient glucometers were used, after each test, the manufacturer's instructions for cleaning and disinfection were to be followed. The facility staff were to utilize a disinfecting product which could be effective against blood borne pathogens.

Personal Cares:

R37's quarterly Minimum Data Set (MDS) dated 2/19/17, identified R37 with severe cognitive impairment and diagnoses including Alzheimer's dementia and anxiety. The MDS indicated R37 required extensive assistance of 1 to 2 staff for all activities of daily living.

On 3/1/17, at 9:30 a.m. R37 was observed in bed as nursing assistant (NA)-I assisted R37 with morning cares. NA-I was observed to wear gloves as she provided R37 with incontinence cares as R37 was incontinent of bowel. At 9:35 a.m. NA-I had completed the perineal cares, removed her gloves and assisted R37 to pull up her pants and transfer from the bed to her wheelchair. NA-I was not observed to wash her hands.

On 3/3/17, at 3:15 p.m. the IDON confirmed the

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F 441	Continued From page 102 staff were to wash their hand after performing perineal cares. The undated Handwashing/Hand Hygiene policy directed the staff to wash their hands after contact with blood or body fluids.	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the standing lift on the memory care unit in a safe, functional and sanitary manner. In addition, failed to ensure the full body mechanical lift was maintained in a safe functional manner. This practice had the potential to affect 2 of 2 residents (R56, R10) who utilized the standing lift and had the potential to affect 6 other residents who utilized the mechanical lifts. Findings include:	F 465	Cornerstone Nursing and Rehab Center strives to maintain a facility that is safe, functional, sanitary and a comfortable environment for residents, staff, and the public. Education and processes have been addressed to assure that this happens. The lift used on R56 and R10 has been cleaned and padding has been replaced with manufacturer recommendations. A cleaning schedule was developed to maintain sanitary conditions of all lifts. Staff educated on 3/22/17 and 3/23/17 regarding the need for all lifts to be	4/15/17

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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
F 465	Continued From page 103 On 3/1/17, at 9:02 a.m. the memory care standing lift was observed to have a thick layer of dirt and debris along the edges of the foot plate. The lift arm detachable cover, next to the belt hooks was noted to be torn and repaired with a thick, black, adhesive duct type tape. On 3/2/17, at 7:40 a.m. a full body mechanical lift was observed in the hallway of the 100 wing. The hydraulic shaft of the machine was observed to be covered in pipe foam and secured in place with one inch black tape. The cross support of the machine (where the full body sling connected) was also observed to be covered with pipe foam and held in place with black tape. On 3/2/17, at 8:50 a.m. nursing assistant (NA)-D was observed to assist R56 from a wheelchair to the toilet via a standing mechanical lift. The foot tray continued to be have dirt and debris on the foot plate. The adhesive tape remained on the lift arm bar. -At 9:00 a.m. NA-D stated the housekeeping staff were responsible for cleaning the standing lift. NA-D stated she did not know when the last time the lift had been cleaned. NA-D confirmed the lift was in need of cleaning. On 3/3/17, at 9:30 a.m. the interim director of nurses (IDON) and registered nurse (RN)-A observed the standing lift on the memory care unit. They confirmed the foot plate contained dirt and debris and the detachable covering was torn	F 465	sanitized with disinfecting wipes between each resident use. Maintenance attached disinfection wipes to a lift on each wing with the exception of memory care, where wipes are located in utility room. All pipe foam and duct tape has been removed by maintenance and will be replaced with manufacturer approved padding. The Director of Nursing or designee shall complete weekly random audits of properly disinfecting of all lifts for 3 weeks or until compliance has been reached. Results of these audits will be reported at the facility Quality Assurance Committee meetings on 4/21/17.	

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 _____	C 03/07/2017

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F 465	Continued From page 104 and covered with tape which created an uncleanable surface. RN-A stated she was not sure who was to ensure the lift was clean. -At 9:45 a.m. the full body mechanical lift was observed in the 100 wing unit with the IDON and RN-A . RN-A stated she did not know why the lift had pipe foam secured with tape. She verified the surface could not be cleaned. The Care of Facility Property policy dated 8/2006, indicated all equipment used was to be spot cleaned when visible soiled. The equipment was also be be cleaned at least weekly by the housekeeping staff.	F 465		
F 497 SS=E	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 12 hours of annual in-service training was completed by 4 of 5 nursing assistants (NA-A, NA-K, NA-L, NA-M) whose personnel records were reviewed. Findings include:	F 497	Cornerstone Nursing and Rehab Center strives to provide yearly performance evaluations and provide regular in-service education. Education and processes have been addressed to assure this occurs. All current identified employees have completed their 12 hours of annual in-service training. Facility secretary will	4/15/17

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F 497	Continued From page 105 Nursing assistant (NA)-A was hired on 7/23/15. Her employee record indicated she had completed 5 of the 12 required training hours for calendar year 2016. NA-K was hired on 10/20/09. Her employee record indicated she had completed 10 of the 12 required training hours for calendar year 2016. NA-L was hired on 9/22/14. Her employee record indicated she had completed 6 of the 12 required training hours for calendar year 2016. NA-M was hired on 8/18/14. Her employee record indicated she had completed 10 of the 12 required training hours for calendar year 2016. On 3/6/17, at 10:15 a.m. the facility secretary (SEC) stated she was responsible to oversee staff training and continuing education units earned and confirmed the total training hours completed for the nursing assistants listed. SEC stated the facility provided monthly online training which the staff were required to complete. SEC also stated when she noticed a staff member was due for training she would notify the respective department head to alert them and the department head was responsible to assure the training was completed. SEC confirmed the aforementioned employees had not completed 12 hours of continuing education training, as required.	F 497	run online education reports monthly to identify employees that have not completed education, these will be given to supervisors. The Online Training policy was reviewed and updated on 3/17/17 to reflect new monthly reports and compliance timeframe for completion. The Director of Nursing or designee shall complete monthly audits of online staff education for 3 months and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility Quality Assurance Committee meeting on 4/21/17.	

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F 497	Continued From page 106 On 3/7/17, at 9:14 a.m. the administrator confirmed it was her expectation nursing assistant staff would complete 12 hours of in-service training, as required. The Online Training policy dated 1/9/15, indicated the secretary would ensure a minimum of 12 courses were available each calendar year.	F 497		

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	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2017**

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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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2017

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two separate buildings due to the construction types and the entire facility is considered existing as of November 1, 2016 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. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction and is separated by a 2 hour fire barrier and the 1968 building was totally remodeled. The facility is completely sprinkler protected with an automatic sprinkler system installed in	K 000		

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K 000	Continued From page 2 accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 43 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide the required self closer's on hazardous rooms as state in the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.4. This deficient practice could allow smoke to enter the corridor making it unusable or difficult for exiting. This could affect the ability to exit for all staff in	K 223	A self closing door device was properly installed and adjusted to close and latch on the records storage room in the basement. All other doors in the facility equipped with self closing devices shall be inspected annually to ensure they close and latch properly. Documentation of the	3/21/17

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K 223	Continued From page 3 the lower level. Findings include: On the facility tour between 9:00 am to 12:30 pm on 2/28/2017 observations and staff interview revealed the door to the record storage room did not have a door closer. This deficient conditions was confirmed by the Environmental Services Director.	K 223	inspection shall be included in the Preventative Maintenance Log. The annual inspection shall be performed by maintenance personnel, monitored by the Environmental Services Supervisor and reported to the Quality Assurance Committee.	
K 331 SS=D	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This STANDARD is not met as evidenced by: Based on observations, staff interview and record review the facility failed to identify the interior finish class of the walls in a storage room with combustible materials as stated in the Life Safety Code, NFPA 101 2012 edition sections 19.3.3.2. This deficient practice could create an additional fuel load in a fire condition and cause a fire to spread more quickly which could affect the exiting of all staff using the lower level. Findings include:	K 331	The wood paneling on the walls of the record storage room were painted with an approved Class A paint. All interior walls and ceilings within the facility have been inspected to ensure approved flame spread rating of Class A or B. A policy and procedures have been developed to ensure approved paint is utilized. All paint used within the facility shall follow the policy and procedures to ensure compliance. All maintenance personnel have been educated on the new policy	3/20/17

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K 331	Continued From page 4 On the facility tour between 9:00 am to 12:30 pm on 2/28/2017 observations and staff interview revealed wood paneling on the walls of the record storage room without documentation to identify the finish class. This deficient condition was confirmed by the Environmental Services Director.	K 331	and procedures. The Environmental Services Supervisor shall be responsible for ensuring compliance by approving fire rated paint purchases prior to any projects involving paint.	
K 364 SS=D	NFPA 101 Corridor - Openings Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to control the openings in a corridor wall in accordance with the 2012 of the Life Safety Code (NFPA 101) section 19.3.6.4.1. This deficient practice could allow for smoke to enter the corridor and make in untenable, affecting the exiting of all staff in the lower level. Findings include:	K 364	Two pieces of 5/8" sheetrock have been added between the transfer grills, including fire caulking around all sides, to the wall in the basement corridor to ensure a one hour fire rating. The Preventative Maintenance Log has been updated to include annual inspection of all interior storage room walls for appropriate fire rating. The annual inspection shall be	3/21/17

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K 364	Continued From page 5 On the facility tour between 9:00 am to 12:30 pm on 2/28/2017 observations and staff interview revealed the basement corridor wall has a louvered transfer grill next to the new storage room door. This deficient condition was confirmed by the Environmental Services Director.	K 364	performed by maintenance personnel, monitored by the Environmental Services Supervisor and reported to the Quality Assurance Committee.	

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Electronically Signed		03/30/2017

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two separate buildings due to the construction types and the entire facility is considered existing as of November 1, 2016 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. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction and is separated by a 2 hour fire barrier and the 1968 building was totally remodeled. The facility is completely sprinkler protected with an automatic sprinkler system installed in	K 000		

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K 000	Continued From page 2 accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 43 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 341 SS=E	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72	K 341	The smoke detector located in the 300 wing adjacent to the med. room was moved to ensure there is 58" between the detector and the heat diffuser. All smoke	3/21/17

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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
K 341	Continued From page 3 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 9 of the 42 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 2/28/2017 observations and staff interview revealed a smoke detector with 36 inches of an HVAC diffuser in the 300 wing adjacent to the med room. This deficient condition was confirmed by the Environmental Services Director	K 341	detectors in the facility shall be inspected annually for proper placement, no less than 36" from an HVAC diffuser. The Preventative Maintenance Log has been updated to include annual inspection of proper placement of smoke detectors/heat diffusers. The annual inspection shall be performed by maintenance personnel, monitored by the Environmental Services Supervisor and reported to the Quality Assurance Committee.	

Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Sunday, April 2, 2017 7:30 PM
To: Whitney, Marian (DPS); Kappenman, Angela (DPS)
Subject: FW: Facility POC Submission All Tags for State MN - P9P321 - CORNERSTONE NSG & REHAB CENTER (Survey Completed 02/28/2017)

OK

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us

-----Original Message-----
From: ePOC_notify@ASPEN.QTSO.com [mailto:ePOC_notify@ASPEN.QTSO.com]
Sent: Thursday, March 30, 2017 6:14 AM
To: King, Maria (MDH) <maria.king@state.mn.us>
Subject: Facility POC Submission All Tags for State MN - P9P321 - CORNERSTONE NSG & REHAB CENTER (Survey Completed 02/28/2017)

Facility: 245307/CORNERSTONE NSG & REHAB CENTER

Facility Type: SNF/NF

Survey Category: RECERT,LSC

Survey Dates: 02/28/2017 - 02/28/2017

Event ID: P9P321

Please note that Plans of Correction (POC) for all tags on the referenced survey above have been submitted and received as of 03/30/2017.

Please do not reply to this message.
Thank you.