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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: QQ04

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 23242

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245612**
2.STATE VENDOR OR MEDICAID NO.
(L2) **884696100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX 724**
(L5) **BUHL, MN** (L6) **55713**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE-NE II 01/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245612 January 31, 2018

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

Dear Ms. Doughty:

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

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

Effective January 8, 2018, the above facility is certified for or recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Peterson

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 31, 2018

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

RE: Project Number S5612016

Dear Ms. Doughty:

On December 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 17, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 8, 2018 and therefore remedies outlined in our letter to you dated December 18, 2017, will not be imposed.

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

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

Sincerely,

Anne Peterson

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QQ04

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(L1) **245612**

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(L3) **CORNERSTONE VILLA**
(L4) **1000 FOREST STREET PO BOX 724**
(L5) **BUHL, MN** (L6) **55713**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
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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)

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17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE-NE II — 01/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 01/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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07/16/2004
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/17/2018 Co.
Sent FSES to ROCHI 01/24/2018 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2017

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

RE: Project Number S5612016

Dear Ms. Doughty:

On December 1, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2018 (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 June 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted November 28 through December 1, 2017 by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		1/8/18

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

Electronically Signed | 12/28/2017

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
	245612	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify family of a urinary tract	F 580	Cornerstone Villa strives to ensure that all residents and/or their representatives are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING _____ B. WING _____	12/01/2017

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

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F 580	Continued From page 2 infection (UTI) and antibiotic use for 1 of 1 residents (R9) reviewed for notification of change. Findings include: On 11/29/17, at 10:12 a.m. family member (FM)-A was interviewed and stated she received a bill from the pharmacy that was different from usual. FM-A noted R9 had been on an antibiotic. FM-A then inquired and was informed R9 had had a UTI. FM-A stated the facility had not informed her of the UTI and antibiotic use, she had found out by reviewing the pharmacy bill. R9's Admission Record printed 12/1/17, indicated R9 had diagnoses that included Alzheimer's disease. R9's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R9 had severely impaired cognition, required extensive assist with toileting and was occasionally incontinent of urine. R9's care plan dated 5/25/16, directed staff to monitor/document changes in urine color, clarity, amount and odor. The care plan further instructed staff to monitor, document and report to the physician any signs or symptoms of a urinary tract infection (UTI). R9's Physician Orders for May 2017, indicated ciprofloxacin HCl (Cipro, an antibiotic) 250 milligrams (mg) by mouth twice daily for 10 days was ordered on 5/2/17. R9's Medication Administration Record (MAR) indicated Cipro was given from 5/2/17, through 5/12/17. R9's medical record lacked indication family was notified of the UTI symptoms or antibiotic use.	F 580	kept informed of all changes in condition and medications and that this notification is documented in the resident's permanent record. Corrective Action R9's family was contacted regarding the facility's failure to notify them of R9's urinary infection, plan of treatment, and outcome of physician ordered treatment. Corrective Action as it Pertains to Others All current resident's records were reviewed for significant changes in condition and notification of family. None were found. P & P was reviewed, revised, and communicated on 12/22/2017 regarding nursing staff's need to communicate all significant changes in condition and medication to resident's and/or their representative. This notification is to be documented in the resident's permanent record. All licensed nursing staff were training on the P & P including documentation of notification. This training occurred on 12/27/2017. Change to Prevent Recurrence The Change in Condition P & P was reviewed, revised, and communicated to all nursing staff and Departmental Managers. Licensed nursing staff were trained on the P & P on 12/27/2017. All significant changes in resident condition will be documented on a "change in condition" flow sheet which will identify the change, intervention, and notification. Monitoring	

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F 580	Continued From page 3 On 12/1/17, at 9:36 a.m. licensed practical nurse (LPN)-B stated the facility informs families when there are signs and symptoms of a UTI, when they order a urinary analysis (UA), and if they start a resident on an antibiotic. On 12/1/17, at 9:43 a.m. registered nurse (RN)-C stated the facility would notify family of any change in condition: a UA, a positive result, the start of an antibiotic. RN-C stated the facility would always let family know, unless family had expressed their they did not want to get these updates. On 12/1/17, at 9:52 a.m. the director of nursing (DON) stated they would let family know if a resident was started on an antibiotic; that was her expectation of staff. The DON stated it, "It's poor notification" if a family found out about a UTI through reviewing a bill and finding the antibiotic listed there. The facility Change in a Resident's Condition or Status policy revised 12/16, directed staff to notify the resident's representative when there was a significant change in the resident's physical, mental or psychosocial status, and this notification was to be made within 24 hours.	F 580	The Director of Nursing or Designee will audit 5 resident change in conditions weekly to determine if the resident and/or family member have been properly notified and the notification is documented in the resident record. These audits will continue until the second quarterly quality assurance committee meeting at which time the committee will review the outcome of the audits to determine if the audits will be continued, reduced, or discontinued.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		1/8/18

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F 657	Continued From page 4 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were allowed to participate in care planning for 1 of 1 residents (R34) reviewed for care plan. Findings include: R34's Admission Record printed 11/30/17 indicated R34 was admitted on 7/26/17. The Admission Record further indicated R34's diagnosis included anemia in chronic kidney disease. R34's quarterly Minimum Data Set (MDS) dated 10/25/17, indicated R34 had moderate cognitive decline.	F 657	Cornerstone strives to ensure that residents and representative are involved in the development of the Resident's individualized plan of care. Corrective Action On 11/30/2017 the ID team held a care conference with R34 and the resident's family member. The resident's needs and preferences were discussed. The resident's individualized plan of care was updated. Corrective Action as it Pertains to Others All current resident records were reviewed to ensure that a care conference was	

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F 657	Continued From page 5 On 11/28/17, at 2:06 p.m. R34 was interviewed and stated she didn't remember attending a care conference, or being included in her plan of care. Review of R34's medical record lacked documentation of care conference for R34. On 11/29/17, at 3:21 p.m. the social worker designee (SWD)-A was interviewed. SWD-A stated she invites residents to their care conferences by telling them, and leaving a note with them. SW-A stated she will also call and invite the resident's family member to the care conference. SW-A stated she was unsure if R34 had a care conference. On 11/30/17, at 8:54 a.m. SWD-A stated she had not scheduled a care conference for R34, and stated she was not sure why this was missed. SWD-A verified she had not included R34 in her plan of care. The facility policy and procedure on Resident Participation - Assessment/Care Plans revised 12/16, directed the resident and his or her legal representative are encouraged to attend and participate in the resident assessment and in the development of the resident's person centered care plan. The policy further directed a seven day advanced notice of the care planning conference is provided to the resident and his or her representative.	F 657	completed with there most current MDS. Changes to Prevent Recurrence The Person-Centered Care Planning P & P was reviewed and presented to the ID team at a team meeting on 12/21/2017 with emphasis on ensuring that the resident and/or family member actively participate in the care planning process including the resident care conference. A flow sheet was developed to track all scheduled resident reviews (initial, quarterly, annual, sig. chg, etc) with a corresponding resident care conference date, mode of resident and/or family notification, attendance. This flow sheet will be reviewed monthly to ensure that all required care conferences have either been completed or rescheduled per the resident and/or family preference. Monitoring The Director of Nursing or Designee will audit three (3) newly completed RAI processes weekly to ensure the process included a resident care conference and that the resident and/or representative were encouraged to participate. These audits will continue until the second quarter quality assurance committee meeting at which time the committee will determine based on the outcome of the audits if these will be continued, decreased, or discontinued.	
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life	F 678		1/8/18

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F 678	Continued From page 6 support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Provider Orders for Life Sustaining Treatment (POLST) was completed for 1 of 2 residents (R28) or accurate for 1 of 2 residents (R21) reviewed for advanced directives. Findings include: R28's admission Minimum Data Set (MDS) dated 9/21/17, indicated R28 was cognitively intact. R28's care plan dated 10/19/17, indicated R28 wished to be full code and cardiopulmonary resuscitation (CPR) would be provided. R28's Physician's Orders signed 11/9/17, indicated R28 was full code status. R28's Health Care Directive signed by R28 on 9/29/17, designated a health care agent but lacked direction on what to do in the event R28's heart stopped. R28's POLST form was in a red envelope on the inside cover of R28's chart. The POLST form included R28's name, birth date and physician's name. The rest of the form was blank and lacked direction of CPR or do not resuscitate (DNR). On 12/1/17, at 9:00 a.m. R28 was interviewed and stated she wanted to have CPR performed in	F 678	Cornerstone Villa strives to ensure that all resident preferences are honored and included in their plan of care. Corrective Action Resident R28 POLST was completed in its entirety which included direction of CPR. The corrected/completed form was placed in the red emergency envelope located at the front of the resident chart. Resident R21's most recent POLST was placed in the emergency envelope located at the front of the resident chart to ensure that R21 receives the treatment per his preference and that the most recent information is provided to emergency personnel. Corrective Action as it Pertains to Others All current resident charts were reviewed for accurate, complete POLST documents and placement of the most current completed POLST document in the red emergency envelope located at the front of each residents' chart. This was completed on 12/22/2017. The POLST P & P was reviewed and revised on 12/21/2017. All licensed nursing staff and the social services designee were provided with this P & P. The procedure was reviewed at the 12/27/2017 staff	

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F 678	Continued From page 7 the event her heart should stop. On 12/1/17, at 9:30 a.m. the director of nursing (DON) verified the POLST form was not completed, and the DON would expect the POLST form to be completed on admission. The DON further stated social service designee (SSD) was discussing this with R28's family. The DON verified the POLST would go with the resident to the hospital and other medical appointments. The DON was asked how health care workers would know wether to perform CPR or not in the event R28's heart stopped. The DON stated they would not. On 12/1/17, at 9:45 a.m. SSD verified R28's advanced directives did not specifically indicate R28's wishes for CPR, and indicated R28's daughter and son were listed as her representatives in the event R28 could not speak for herself. A POLST policy was requested and not received. R21's Physician Orders dated 12/1/17, included order for full code status (an order to provide CPR, if R21's heart were to stop beating, or if R21 were to stop breathing.) R21's Resuscitation Guidelines signed by R21 on 4/26/14, directed staff to perform CPR if R21's heart were to stop beating or R21 were to stop breathing.	F 678	inservice with emphasis on accurate and complete completion of the POLST document and proper placement of the most current POLST in the red emergency envelope located at the front of each resident chart. Monitoring The Director of Nursing or designee will audit all newly admitted resident charts to determine if the POLST document is accurately completed in its entirety and that this document is properly placed in the red emergency envelope located at the front of each residents' chart. The audits will continue until the second quarterly quality assurance committee meeting at which time the committee will determine, based on the outcome of the audits, if the audit will be continued, decreased, or discontinued.	

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F 678	Continued From page 8 R21's Resuscitation Guidelines signed on 3/22/13, by R21 directed not to resuscitate (DNR). These guidelines were placed in the front of R21's chart, in a red envelope, for emergency personal in the event of an emergency or transfer out of the facility. R21's care plan dated 12/1/17, directed staff to honor the wishes of R21 and provide CPR. On 12/1/17, at 11:00 a.m. the director of nursing (DON) verified R21's emergency paperwork was not in agreement with R21's directive to resuscitation. The DON stated she expected the paperwork in the emergency envelope to have been the most recent resuscitation orders signed and ordered. The DON verified the information in the red emergency envelope was not R21's most recent resuscitation guidelines.	F 678		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/5/18

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F 761	Continued From page 9 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an insulin vial was labeled accurately for 1 of 1 residents R38 observed to receive insulin injection. R38's Face Sheet printed 11/30/17, included diagnosis of type 2 diabetes. R38's Physician Orders dated 8/23/17, included order for Novolin N (insulin) 16 units (U) every day before breakfast. On 11/3/17, at 10:46 a.m. registered nurse (RN)-A was observed during medication pass. RN-A stated the label on R38's Novolin N insulin did not match the dosage directions on the electronic Medication Administration Record (eMAR). RN-A checked the physician order prior to drawing up R38's insulin. RN-A stated the vial directed staff to inject 14 U before breakfast, and the eMAR directed staff to inject 16 U before breakfast. R38's Physican Orders signed 10/5/17, directed staff to increase insulin from 14 U before breakfast to 16 U before breakfast. On 11/30/17, at 10:53 a.m. RN-A confirmed the	F 761	Cornerstone Villa strives to ensure that all pharmaceutical products are labeled, store, dispensed, and removed per the facility policy. Corrective action A "refer to Chart" sticker was placed on the medication card of R38's insulin vial on 12/01/2017. Corrective Action as it Pertains to Others The P & P for Labeling of Medication Containers has been reviewed and does include directions for medication direction changes. This P & P was presented to all licensed nursing staff on 12/1/2017 and was discussed at the 12/27/2017 mandatory nursing staff inservice training. All medications in the medication carts and medication rooms have be audited to ensure that the labeling matches the resident records and physician orders. This was completed on 12/4/2017. Changes to Prevent Recurrence All licensed nursing staff have been retrained on the P & P for "Labeling Medication Containers". All medication	

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F 761	Continued From page 10 insulin label was not correct and that the insulin label should have had an orange sticker on it directing staff to refer to the Physician's Order of 10/5/17, when the order changed. RN-A placed the orange "Refer to chart" label sticker on R38's insulin vial. RN-A stated pharmacy would be updated of new order. On 11/30/17, at 1:21 a.m. the director of nursing (DON) was interviewed and stated she would expect the insulin label to have had an orange sticker directing staff to refer to Physician's Orders of 10/15/17, when the order was changed. The facility policy Medication Labels dated 6/17, directed staff to place a "direction change - refer to chart" sticker on any inaccurate medication label. The staff were directed to check the medication administration record (MAR) or the physicians order for current information. The dispensing pharmacy was to be informed prior to the next refill of the prescription so the new container would show an accurate label.	F 761	direction changes will be documented in the resident record, a "refer to chart" label will be placed on the medication, and each will be documented on a medication change flow sheet. The night shift nurse will check the order change to ensure it is documented on the flow sheet and will verify that a label has been placed on the medication. Monitoring The Director of Nursing, or designee, will all medication change orders to verify that these are documented in the resident record and the flow sheet and a label has been placed on the medication. These Audits will continue until the second quarter quality assurance committee meeting at which time the committee, based on the outcome of the audits, will determine if the audits will be continued, decreased or discontinued.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 804	Cornerstone Villa strives to ensure that	1/8/18

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F 804	Continued From page 11 review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1of 3 residents (R9) reviewed for food. Findings include: R9's Admission Record printed 12/1/17, indicated R9 had diagnoses that included Alzheimer's disease. R9's quarterly Minimum Data Set (MDS), dated 9/1/17, indicated R9 had severely impaired cognition and required only set-up assistance with eating. On 11/29/17, at 10:00 a.m. family member (FM)-A stated she had taken pictures of R9's food at times because the food isn't done well and she wouldn't think anyone would believe her if she didn't take a picture. FM-A stated one night the chicken was so burnt that is was not edible. On 12/1/17, at 11:52 a.m. food service for the lunch meal began on the Willows unit. On 12/1/17, at 12:11 a.m. a tray was requested and tested. The meal included french fries and a cheeseburger. The french fries were barely warm and the hamburger was neither warm nor palatable. On 12/1/17, at 12:15 p.m. the plated hamburger temperature was 104 degrees Fahrenheit (F) and the french fries were at 100 degrees F. On 12/1/17, at 12:20 p.m. cook (C)-A stated they must serve food between the temperatures of 135-145 and that was not very hot. C-A stated they would heat food up in the microwave if	F 804	resident meals not only meet the resident nutritional needs but are also palatable. Corrective Action The P & P for food temperatures was reviewed and updated with the assistance of the facility Dietary Consultant to include direction on temperatures for food palatability. The food temperatures were audited and adjusted to reflect the changes in the P & P. Staff received formal training on 12/27/2017 regarding changes to the P & P. R9 and family member will be surveyed periodically to determine if the corrections made are improving R9's dining experience Corrective Action as it Pertains to Others Dietary staff have been training on both safe serve food temperatures as well as palatable food preparation and service. This training began on 12/4/2017 with dietary staff mandatory training on 12/27/2017. Staff, residents, and family members will be asked to complete food service surveys to determine if the meal served is palatable and the dining experience is enjoyable. Dietary staff will be taking and documenting food temperature to ensure that the temperatures of the food are within the safe zone and are also palatable per the P & P. Changes to Prevent Recurrence The Dietary Director will monitor foods temperatures at least 5 times per week at various meal times, initiate ongoing resident, family member, and staff food	

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F 804	Continued From page 12 requested. C-A stated they used the microwave quite a bit to heat up food. C-A stated food was delivered to steam tables in each unit (Willows, Tamarack, and then Birch). C-A stated the food would sit in the steam tables in Willows for about an hour. C-A stated when potatoes were served, those were kept in the kitchen's warming ovens until staff were ready to serve residents; then a staff person would bring them out. C-A stated the steam table in the Tamarack unit doesn't seem to hold the food hot, but she had not brought that to the attention of maintenance. On 12/1/17, at 1:57 p.m., the Dietary Services Director (DSD) stated dietary staff would turn on the steam tables and the plate warmers about an hour prior to service time. Food would be "dropped" into steam tables on the units in the order of Willows, Tamarack and then Birch, which was served first. The DSD stated she has had only random complaints of cold food. The DSD stated food has to be served between the temperatures of 135 to 145 degrees F. The facility Point of Service Temping policy dated 7/2/12, directed the safe temperature zone for hot foods was between 135 degrees F - 145 degrees F. The policy lacked direction on temperatures for food palatability.	F 804	quality surveys to obtain feed back to determine of the new procedures are effective or if changes and/or addition training need to be initiated. An IDT food committee has been formed to review the surveys, develop and initiate further data collection if needed, and to assist in the development identified changes. The Food Committee will meeting weekly for the until the second quarter quality assurance committee meeting at which time the quality assurance committee will determine if the food committee meeting frequency will be reduced to a monthly meeting. This decision will be based on the outcome of a facility wide resident and family member dining satisfaction survey. Monitoring The Administrator, or designee, will audit food service survey outcomes and changes made to address any negative outcomes, ensure that an adequate number of residents, family members, and staff are surveyed on each unit and at various meal times. The Dietary Director will audit the food temperatures of 1 meal per day, on 5 days per week to ensure the temperatures meet the requirements of the P&P and are at palatable temperature levels and appearance. These audits will continue until the second quarter quality assurance committee meeting at which time the committee will determine based on the audits and survey outcomes if the audits will be decreased, increased, or discontinued. Also, based on the food committee recommendation and outcome of the satisfaction survey, the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 13	F 804	assurance committee will determine if the IDT Food Committee weekly meeting will remain weekly meetings or will become monthly meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**11/29/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Cornerstone Villa was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/28/2017

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
	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**11/29/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Cornerstone Villa is a one story building with no basement. It was constructed in 2003-2004. The construction type was determined to be Type V (111). This building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**11/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA Life Safety Code 101 (12), Sections 18.3.7 and 18.3.7.3. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect all 41 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 11/29/2017, it was observed that in the attic the smoke barrier that ran the entire length of the building was constructed of drywall on one side wood studs only. The smoke barrier is required to have a 1-hour fire resistant rating. Drywall on one side of wood studs does not have a 1-hour fire resistive rating.	K 372	Correction not needed - Cornerstone Villa has achieved a passing FSES score: See attached FSES/HC	12/21/17

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	245612	A. BUILDING **01 - MAIN BUILDING 1** B. WING _____	**11/29/2017**

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

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K 372	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 41 of 41 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 11/29/2017, during the review of all available fire drill documentation and interview with the	K 712	Corrective Action A fire drill was conducted on 12/7/2017 at 9:15 AM. Change to Prevent Recurrence The Maintenance Director, or designee, will log all fire drills on a flow sheet which will not the date, time of day, and location to ensure that the fire drill are held at unexpected varying times under varying conditions, at least quarterly on each shift. The maintenance director will review the log prior to the end of each quarter to ensure that all required drills were completed.	12/8/17

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K 712	Continued From page 4 Maintenance Supervisor the following deficient conditions it was revealed that the facility had failed to conduct 1 day shift fire drill in the fourth quarter. This deficient condition was verified by a Maintenance Supervisor.	K 712	Monitoring The Administrator, or designee, will review the logs and fire drill reports to determine if the required drills were logged and conducted as required per the Fire Drill Policy & Procedure. These audits will continue until the second quarter quality assurance committee meeting at which time the committee will determine, based of the audits and review of the flow sheet, if the audits will be continued or discontinued.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 41 of 41 residents, as well as an undetermined number of staff, and visitors.	K 901	The facility risk assessment has been reviewed and updated to include all of the systems that are identified in chapter 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition.	12/8/17

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K 901	Continued From page 5 Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 11/29/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility has a risk assessment document but upon reviewing the document it was found that the assessment was incomplete. The current risk assessment did not account for all of the systems that are identified in chapter 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was verified by the Maintenance Supervisor.	K 901		

REPORT OF CONSULTANT FSES FINDINGS

Cornerstone Villa

1000 Forest Street, PO Box 724

Buhl, MN 55713

Provider No. 245612

Date of Survey: December 14 & 19, 2017

Prepared by:
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December 21, 2017

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

RE: FSES at Cornerstone Villa

Dear Ms. Doughty:

Enclosed please find the survey information related to the fire safety evaluation of Cornerstone Villa, 1000 Forest Street, Buhl, MN conducted on 12/14/2017. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(2013), *Guide on Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2012 edition of the *Life Safety Code®* (NFPA 101). An FSES was made necessary in this case because of a smoke barrier wall (K372) deficiency cited during a fire/life safety recertification survey conducted on 11/29/2017.

The following factors served as the basis for this evaluation:

- Because the building was constructed prior to 07/05/2016, Cornerstone Villa was considered an existing building.
- Cornerstone Villa is one story in height and has no basement. For purposes of this FSES, the building was divided into three (3) separate smoke zones.

Based on conditions as found during the FSES evaluation conducted on 12/14/2017 and as reported in a follow-up email from you, received at 0830 hours on 12/21/2017, all four parameters in Worksheet 4.7.9 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three (3) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Cornerstone Villa has achieved a passing FSES score.

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

Wishing you a safe day!

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

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: Cornerstone Villa
Address: 1000 Forest Street, PO Box 724, Buhl, MN 55713
Phone: 218-258-3253
Licensed capacity: 44
Census at time of survey: 39

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0855 hours and 1300 hours on 12/14/2017. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(13), *Guide on Alternative Approaches to Life Safety*. Based on this evaluation, Cornerstone Villa has achieved a passing score on the FSES.

An FSES was made necessary because of a smoke barrier wall deficiency cited during a fire/life safety recertification survey conducted on 11/29/2017. The deficiency was issued because the smoke barrier wall that runs the entire length of the building was found to be constructed of drywall on only one side of wood studs (see data tag K372). A single layer of drywall installed on one side of wood studs does not provide the 1-hour fire-resistance rating required by NFPA 101(12), Sections 18.3.7.3 and 4.6.12.2.

In addition to observations made and documentation review conducted during the 12/14/2017 on-site visit, the findings outlined herein are based on:

- Information provided by Ms. Debra Doughty, Administrator, and Mr. Jeff Dobson, Environmental Services Director; and
- A review of the Statement of Deficiencies (Form CMS-2567) resulting from the fire/life safety recertification survey conducted on 11/29/2017.
- A follow-up e-mail communication received from the facility Administrator at 0830 hours on 12/21/2017 confirming that a corroded fire sprinkler found at the Tamarack Unit Shower Room had been replaced.

Initial Comments:
The building housing Cornerstone Villa was constructed in 2003-2004 and occupied in 2004. Because the building was constructed prior to 07/05/2016, it is considered an existing building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

The building is one story in height with an unfinished attic space and has no basement. Based on observation, interview of the Environmental Services Director and review of the Code Summary attached to the building construction drawings, the building's wood frame structural members (exterior walls, interior bearing walls and roof/ceiling assembly) are protected with materials providing a fire resistance rating of one hour. As a result, the building was assigned a Type V(111) construction type in accordance with NFPA 220(12), Sec. 4.6 and Table 4.1.1.

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

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

Surveyor Note: A corroded fire sprinkler was found in the Tamarack Unit Shower Room located across the corridor from Resident Room 321 at the time of the 12/14/2017 on-site visit. NFPA 25(11), Sec. 5.2.1.1.4 requires that any sprinkler that is corroded be replaced. In a follow-up e-mail communication received at 0830 hours on 12/21/2017, the facility Administrator confirmed that the corroded fire sprinkler was replaced on 12/19/2017. A copy of the sprinkler contractor's Work Authorization Report was provided to serve as verification that the sprinkler had been replaced. The findings in this report, therefore, reflect that the building's fire sprinkler protection is in conformance with the requirements of NFPA 101(12), Sec. 19.3.5.1 and the fire sprinkler system is now being inspected, tested and maintained in accordance with NFPA 25.

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

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

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

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

This report is intended to serve as an explanation of the scores entered on FSES Worksheets 4.7.2, 4.7.6 and 4.7.10 (i.e. Forms CMS-2786T) for the facility as it was found on 12/14/2017 and as reported in the follow-up email from the facility Administrator received on 12/21/2017. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Worksheet 4.7.5 (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2013 edition of NFPA 101A and the 2012 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Worksheet 4.7.10, which applies to all zones, this narrative will address each of the facility's three (3) smoke zones separately.

All Zones – WORKSHEET 4.7.10. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(13), Sec. 4.7.9, Step 9, only one copy of this worksheet is required to be filled out for each building. For convenience, however, this worksheet was filled out for each of the three zones evaluated. All items in Worksheet 4.7.10 could be checked 'Met' with the exception of Items B and L. Because Cornerstone Villa is an existing facility and does not meet the definition of a high rise, Items B and L do not apply in this case and were checked 'Not Applicable'.

The remaining items in Worksheet 4.7.10 were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(12), Sections 9.1 and 9.2.
- No incinerator or portable space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
  Surveyor Note: A review of the Statement of Deficiencies from the 11/29/2017 fire/life safety recertification survey revealed that the facility was cited for failure to conduct a day shift fire drill in the fourth quarter of 2017 (see data tag K712). Based on interview of the Administrator and Environmental Services Director, this was caused by a fire drill being conducted out of sequence in the fourth quarter of 2016. Based on documentation review conducted at the time of the 12/14/2017 on-site visit, a day shift fire drill was conducted on 12/07/2017. As a result, it was confirmed that the facility has conducted quarterly fire drills on each shift in 2017 as required by NFPA 101(12), Sec. 19.7.1.6.
- The facility's smoking regulations were reviewed and appeared to be in order. Cornerstone Villa is a smoke-free facility.
- Based on observation, documentation review and interview of the Administrator and Environmental Services Director, all draperies, cubicle curtains, upholstered furniture, mattresses and decorations appear to be in accordance with NFPA 101(12), Sec. 19.7.5.
- Portable fire extinguishers appeared to be provided in accordance with applicable requirements.
- EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Tamarack and Birch Units:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

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

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of gypsum wallboard with wood paneling at several locations. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure approximately 142 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: -5]:
   This score was assigned because, in the attic space, the smoke barrier wall between this zone and Zone 2 (Support Services) is constructed of gypsum board (drywall) installed on one side of wood studs, which does not provide the 1-hour fire resistance required by NFPA 101(12), Sections 18.3.7.3 and 4.6.12.2.. It could not be confirmed at the time of this FSES survey that the construction of the ceiling assembly at which the smoke barrier wall terminates meets the exceptions to NFPA 101(12), Sec. 8.5.2 and Sec. 8.3.1.2(2).
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected automatic smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 2 – Support Services:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

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

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

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

3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Wood paneling was found in the Administrator's office. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating. Four (4) 22½-in. x 52-in. tempered glass vision panels were found in the corridor wall at the activity room and a 12-in. x 74-in. tempered glass sidelight was found in the corridor wall at the chapel. It was found that these spaces are protected with automatic smoke detection to meet NFPA 101(12), Sec. 19.3.6.1(1) for spaces allowed to be open to the corridor.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames. Both leaves of the set of double doors into the activity room were found to have 24-in. x 33-in. tempered glass vision panels in them. It was found that this space is protected with automatic smoke detection to meet NFPA 101(12), Sec. 19.3.6.1(1) for spaces allowed to be open to the corridor.
6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure approximately 213 ft in length and has no dead ends in excess of 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   There is a smoke barrier located between this zone and Zone 3 (Willow Unit) that serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridor and spaces open to the corridor. The zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 3 – Willow Unit:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

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

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of gypsum wallboard with wood paneling at the scale alcove. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating. Based on documentation review and interview of the Environmental Services Director, the wood paneling has been treated with Flame Control No. 6, Flame Control No. 166 and Flame Control No. 167 in a 3-step process to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard. Ceilings were found to be a mixture of gypsum wallboard and acoustical ceiling tile. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a ceiling assembly consisting of two layers of 5/8-in.-thick Type X gypsum board constructed in accordance with Table 719.1(3), Item Number 21-1.1, of the 2000 International Building Code to achieve a 1-hour fire protection rating.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction installed in metal frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure approximately 131 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   There is a smoke barrier located between this zone and Zone 2 (Support Services) that serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.

11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by WH Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all sleeping rooms. Because this condition does not meet the criteria specified in NFPA 101A(2013), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions as found between 0855 hours and 1300 hours on 12/14/2017 and as reported by the facility Administrator in an email communication received at 0830 hours on 12/21/2017. Any changes in those conditions after those dates could affect the scores and values, either positively or negatively. Again, based on this evaluation, Cornerstone Villa **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 1 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
Cornerstone Villa	1000 Forest St, PO Box 724, Buhl, MN 55713		
ZONE(S) EVALUATED			
Tamarack & Birch Units			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245612	12/19/2017		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert W. Simkulta	President	Fire Safety Resources, LLC	12/21/2017
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.5	X	1.2	=	12.1

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	12.1	=	7.6 ⇒ 8

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C		Class B		Class A		
	-5(0)[f]		0(3)[f]		(3)		
3. Interior Finish (Rooms)	Class C		Class B		Class A		
	-3(1)[f]		1(3)[f]		(3)		
4. Corridor Partitions/Walls	None or Incomplete		<½ hour		>½ to <1 hour	≥1 hour	
	-10(0)[a]		0		1(0)[a]	(2(0))[a]	
5. Doors to Corridor	No Door		<20 min FPR		≥ 20 min FPR	≥ 20 min FPR and Auto Closure	
	-10		0		(1(0))[d]	2(0)[d]	
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	(0(0))[h]	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0))[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	(-5(0))[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

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

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 19 — S_a 0	C = 19	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 16 — S_b 10	E = 6	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 8 — S_c 0	P = 8	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 20 — R 8	G = 12	✓	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		☒
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		☒
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		☒
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		☒
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		☒
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	✓		☒
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 2 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
Cornerstone Villa	1000 Forest St, PO Box 724, Buhl, MN 55713		
ZONE(S) EVALUATED			
Support Services			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245612	12/19/2017		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert J. Imholte	President	Fire Safety Resources, LLC	12/21/2017
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

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

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	10.1	=	6.1 = 7

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C		Class B		Class A		
	-5(0)[f]		0(3)[f]		(3)		
3. Interior Finish (Rooms)	Class C		Class B		Class A		
	-3(1)[f]		1(3)[f]		(3)		
4. Corridor Partitions/Walls	None or Incomplete		<½ hour		>½ to <1 hour	≥1 hour	
	-10(0)[a]		0		1(0)[a]	(2(0))[a]	
5. Doors to Corridor	No Door		<20 min FPR		≥ 20 min FPR	≥ 20 min FPR and Auto Closure	
	-10		0		(1(0))[d]	2(0)[d]	
6. Zone Dimensions	Dead End				No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.		>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]		(-2(0))[c] (0)[h]	0(0)[h]	1
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.		≥1 hr. to <2 hr.		≥2 hr.
	-14	-10	0		(2(0))[e]		3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency			No Deficiencies	
	In Zone	Outside Zone	In Zone		In Adjacent Zone		
	-11	-5	-6		-2		(0)
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes				Direct Exit(s)	
	-8	Deficient	W/O Horizontal Exit(s)		Horizontal Exit(s)		
		-2	(0)		1		5
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.			W/F.D. Conn.		
	-4	1			(2)		
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only		Corridor and Habit. Spaces	Total Spaces in Zone	
	0(3)[g]	(2(3))[g]	3(3)[g]		4		5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

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

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 19	S_a 0	C = 19	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15	S_b 10	E = 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 10	S_c 0	P = 10	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 22	R 7	G = 15	√	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 3 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
Cornerstone Villa	1000 Forest St, PO Box 724, Buhl, MN 55713		
ZONE(S) EVALUATED			
Willow Unit			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245612	12/19/2017		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert J. Ventetta	President	Fire Safety Resources, LLC	12/21/2017
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

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

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	9.5	=	5.7 = 6

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2)(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	0	(1)(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	(0)(0)[h]	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	(2)(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 19	S_2= 15	S_3= 12	S_4= 24

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 19	S_a 0	C = 19	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15	S_b 10	E = 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 12	S_c 0	P = 12	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 24	R 6	G = 18	√	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

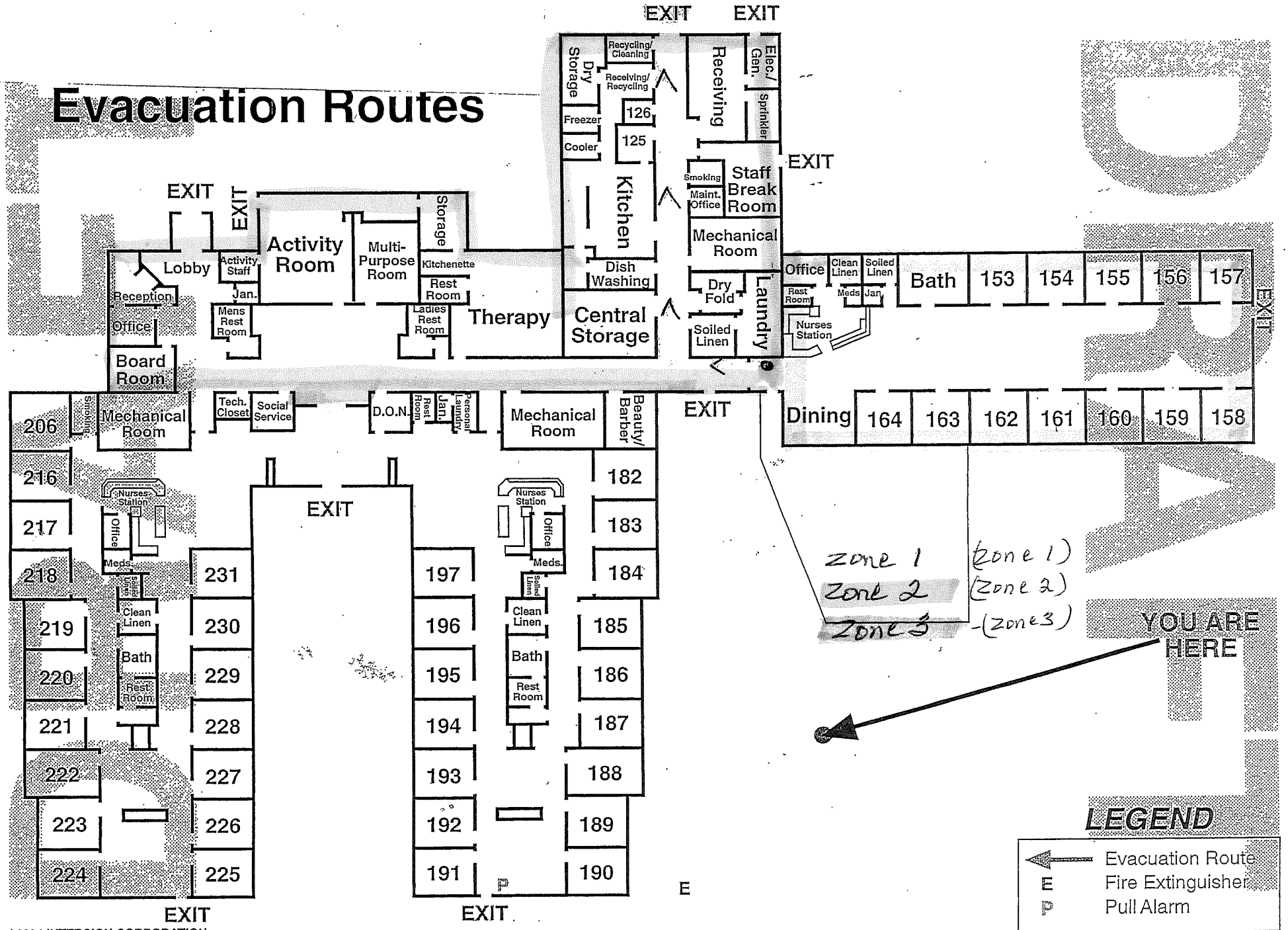
WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

Evacuation Routes



ORDER #2346052B IJO #6209 EVAC 1 APPROVAL:_____ DATE: _____

Electronically delivered
December 18, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5612016

Dear Ms. Doughty:

The above facility was surveyed on November 28, 2017 through December 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Unit Supervisor Teresa Ament at: teresa.ament@state.mn.us or (218) 302-6151.

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

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

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23242	A. BUILDING: _____ B. WING _____	12/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/28/17 through 12/1/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		1/8/18

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify family of a urinary tract infection (UTI) and antibiotic use for 1 of 1 residents (R9) reviewed for notification of change. Findings include: On 11/29/17, at 10:12 a.m. family member (FM)-A was interviewed and stated she received a bill from the pharmacy that was different from usual. FM-A noted R9 had been on an antibiotic. FM-A then inquired and was informed R9 had had a UTI. FM-A stated the facility had not informed her of the UTI and antibiotic use, she had found out by reviewing the pharmacy bill. R9's Admission Record printed 12/1/17, indicated R9 had diagnoses that included Alzheimer's disease. R9's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R9 had severely impaired cognition, required extensive assist with toileting and was occasionally incontinent of urine. R9's care plan dated 5/25/16, directed staff to monitor/document changes in urine color, clarity, amount and odor. The care plan further instructed staff to monitor, document and report to the physician any signs or symptoms of a urinary tract infection (UTI). R9's Physician Orders for May 2017, indicated ciprofloxacin HCl (Cipro, an antibiotic) 250 milligrams (mg) by mouth twice daily for 10 days	2 265	Corrected	

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2 265	Continued From page 4 was ordered on 5/2/17. R9's Medication Administration Record (MAR) indicated Cipro was given from 5/2/17, through 5/12/17. R9's medical record lacked indication family was notified of the UTI symptoms or antibiotic use. On 12/1/17, at 9:36 a.m. licensed practical nurse (LPN)-B stated the facility informs families when there are signs and symptoms of a UTI, when they order a urinary analysis (UA), and if they start a resident on an antibiotic. On 12/1/17, at 9:43 a.m. registered nurse (RN)-C stated the facility would notify family of any change in condition: a UA, a positive result, the start of an antibiotic. RN-C stated the facility would always let family know, unless family had expressed their they did not want to get these updates. On 12/1/17, at 9:52 a.m. the director of nursing (DON) stated they would let family know if a resident was started on an antibiotic; that was her expectation of staff. The DON stated it, "It's poor notification" if a family found out about a UTI through reviewing a bill and finding the antibiotic listed there. The facility Change in a Resident's Condition or Status policy revised 12/16, directed staff to notify the resident's representative when there was a significant change in the resident's physical, mental or psychosocial status, and this notification was to be made within 24 hours. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	2 265		

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2 265	Continued From page 5 procedures to ensure residents/family representatives are notified of a change in condition or treatment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were allowed to participate in care planning for 1 of 1 residents (R34) reviewed for care plan.	2 555	Corrected	1/8/18

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2 555	Continued From page 6 Findings include: R34's Admission Record printed 11/30/17 indicated R34 was admitted on 7/26/17. The Admission Record further indicated R34's diagnosis included anemia in chronic kidney disease. R34's quarterly Minimum Data Set (MDS) dated 10/25/17, indicated R34 had moderate cognitive decline. On 11/28/17, at 2:06 p.m. R34 was interviewed and stated she didn't remember attending a care conference, or being included in her plan of care. Review of R34's medical record lacked documentation of care conference for R34. On 11/29/17, at 3:21 p.m. the social worker designee (SWD)-A was interviewed. SWD-A stated she invites residents to their care conferences by telling them, and leaving a note with them. SW-A stated she will also call and invite the resident's family member to the care conference. SW-A stated she was unsure if R34 had a care conference. On 11/30/17, at 8:54 a.m. SWD-A stated she had not scheduled a care conference for R34, and stated she was not sure why this was missed. SWD-A verified she had not included R34 in her plan of care. The facility policy and procedure on Resident Participation - Assessment/Care Plans revised 12/16, directed the resident and his or her legal representative are encouraged to attend and participate in the resident assessment and in the development of the resident's person centered	2 555		

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2 555	Continued From page 7 care plan. The policy further directed a seven day advanced notice of the care planning conference is provided to the resident and his or her representative. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure residents or their representative actively participates in the care conferences. All appropriate staff could be educated on the process of resident/representative involvement. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1of 3 residents (R9) reviewed for food. Findings include: R9's Admission Record printed 12/1/17, indicated R9 had diagnoses that included Alzheimer's	2 960	Corrected	1/8/18

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2 960	Continued From page 8 disease. R9's quarterly Minimum Data Set (MDS), dated 9/1/17, indicated R9 had severely impaired cognition and required only set-up assistance with eating. On 11/29/17, at 10:00 a.m. family member (FM)-A stated she had taken pictures of R9's food at times because the food isn't done well and she wouldn't think anyone would believe her if she didn't take a picture. FM-A stated one night the chicken was so burnt that is was not edible. On 12/1/17, at 11:52 a.m. food service for the lunch meal began on the Willows unit. On 12/1/17, at 12:11 a.m. a tray was requested and tested. The meal included french fries and a cheeseburger. The french fries were barely warm and the hamburger was neither warm nor palatable. On 12/1/17, at 12:15 p.m. the plated hamburger temperature was 104 degrees Fahrenheit (F) and the french fries were at 100 degrees F. On 12/1/17, at 12:20 p.m. cook (C)-A stated they must serve food between the temperatures of 135-145 and that was not very hot. C-A stated they would heat food up in the microwave if requested. C-A stated they used the microwave quite a bit to heat up food. C-A stated food was delivered to steam tables in each unit (Willows, Tamarack, and then Birch). C-A stated the food would sit in the steam tables in Willows for about an hour. C-A stated when potatoes were served, those were kept in the kitchen's warming ovens until staff were ready to serve residents; then a staff person would bring them out. C-A stated the	2 960		

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2 960	Continued From page 9 steam table in the Tamarack unit doesn't seem to hold the food hot, but she had not brought that to the attention of maintenance. On 12/1/17, at 1:57 p.m., the Dietary Services Director (DSD) stated dietary staff would turn on the steam tables and the plate warmers about an hour prior to service time. Food would be "dropped" into steam tables on the units in the order of Willows, Tamarack and then Birch, which was served first. The DSD stated she has had only random complaints of cold food. The DSD stated food has to be served between the temperatures of 135 to 145 degrees F. The facility Point of Service Temping policy dated 7/2/12, directed the safe temperature zone for hot foods was between 135 degrees F - 145 degrees F. The policy lacked direction on temperatures for food palatability. The director of nursing (DON) and/or designee could identify and develop a more palatable dining experience and could provide appropriate staff education regarding food preparation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced	21620		1/5/18

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 10 by: Based on observation, interview, and document review, the facility failed to ensure an insulin vial was labeled accurately for 1 of 1 residents R38 observed to receive insulin injection. R38's Face Sheet printed 11/30/17, included diagnosis of type 2 diabetes. R38's Physician Orders dated 8/23/17, included order for Novolin N (insulin) 16 units (U) every day before breakfast. On 11/3/17, at 10:46 a.m. registered nurse (RN)-A was observed during medication pass. RN-A stated the label on R38's Novolin N insulin did not match the dosage directions on the electronic Medication Administration Record (eMAR). RN-A checked the physician order prior to drawing up R38's insulin. RN-A stated the vial directed staff to inject 14 U before breakfast, and the eMAR directed staff to inject 16 U before breakfast. R38's Physican Orders signed 10/5/17, directed staff to increase insulin from 14 U before breakfast to 16 U before breakfast. On 11/30/17, at 10:53 a.m. RN-A confirmed the insulin label was not correct and that the insulin label should have had an orange sticker on it directing staff to refer to the Physician's Order of 10/5/17, when the order changed. RN-A placed the orange "Refer to chart" label sticker on R38's insulin vial. RN-A stated pharmacy would be updated of new order. On 11/30/17, at 1:21 a.m. the director of nursing (DON) was interviewed and stated she would expect the insulin label to have had an orange	21620	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23242	A. BUILDING: _____ B. WING _____	12/01/2017

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21620	Continued From page 11 sticker directing staff to refer to Physician's Orders of 10/15/17, when the order was changed. The facility policy Medication Labels dated 6/17, directed staff to place a "direction change - refer to chart" sticker on any inaccurate medication label. The staff were directed to check the medication administration record (MAR) or the physicians order for current information. The dispensing pharmacy was to be informed prior to the next refill of the prescription so the new container would show an accurate label. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are labeled appropriately. The DON or designee could educate staff on these policies and procedures. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days	21620		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but	21840		1/8/18

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21840	Continued From page 12 has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Provider Orders for Life Sustaining Treatment (POLST) was completed for 1 of 2 residents (R28) or accurate for 1 of 2 residents (R21) reviewed for advanced directives. Findings include: R28's admission Minimum Data Set (MDS) dated 9/21/17, indicated R28 was cognitively intact. R28's care plan dated 10/19/17, indicated R28 wished to be full code and cardiopulmonary resuscitation (CPR) would be provided. R28's Physician's Orders signed 11/9/17, indicated R28 was full code status. R28's Health Care Directive signed by R28 on 9/29/17, designated a health care agent but lacked direction on what to do in the event R28's heart stopped. R28's POLST form was in a red envelope on the inside cover of R28's chart. The POLST form included R28's name, birth date and physician's name. The rest of the form was blank and lacked direction of CPR or do not resuscitate (DNR). On 12/1/17, at 9:00 a.m. R28 was interviewed	21840	Corrected	

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	23242	A. BUILDING: _____ B. WING _____	12/01/2017

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21840	Continued From page 13	21840		

and stated she wanted to have CPR performed in the event her heart should stop.

On 12/1/17, at 9:30 a.m. the director of nursing (DON) verified the POLST form was not completed, and the DON would expect the POLST form to be completed on admission. The DON further stated social service designee (SSD) was discussing this with R28's family. The DON verified the POLST would go with the resident to the hospital and other medical appointments. The DON was asked how health care workers would know wether to perform CPR or not in the event R28's heart stopped. The DON stated they would not.

On 12/1/17, at 9:45 a.m. SSD verified R28's advanced directives did not specifically indicate R28's wishes for CPR, and indicated R28's daughter and son were listed as her representatives in the event R28 could not speak for herself.

A POLST policy was requested and not received.

R21's Physician Orders dated 12/1/17, included order for full code status (an order to provide CPR, if R21's heart were to stop beating, or if R21 were to stop breathing.)

R21's Resuscitation Guidelines signed by R21 on 4/26/14, directed staff to perform CPR if R21's heart were to stop beating or R21 were to stop breathing.

R21's Resuscitation Guidelines signed on 3/22/13, by R21 directed not to resuscitate (DNR). These guidelines were placed in the front of R21's chart, in a red envelope, for emergency personal in the event of an emergency or transfer

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21840	Continued From page 14 out of the facility. R21's care plan dated 12/1/17, directed staff to honor the wishes of R21 and provide CPR. On 12/1/17, at 11:00 a.m. the director of nursing (DON) verified R21's emergency paperwork was not in agreement with R21's directive to resuscitation. The DON stated she expected the paperwork in the emergency envelope to have been the most recent resuscitation orders signed and ordered. The DON verified the information in the red emergency envelope was not R21's most recent resuscitation guidelines. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21840		