



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 12, 2025

Administrator
Cornerstone Nsg & Rehab Center
416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

RE: CCN: 245307
Cycle Start Date: July 9, 2025

Dear Administrator:

On August 28, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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September 12, 2025

Administrator

Cornerstone Nsg & Rehab Center

416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

Re: Reinspection Results
Event ID: UVR412

Dear Administrator:

On August 28, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 9, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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July 29, 2025

Administrator
Cornerstone Nsg & Rehab Center

416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

RE: CCN:245307

Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025 a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

If substantial compliance with the regulations is not verified by October 9, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by January 9, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>. This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 7/7/25 through 7/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			07/29/2025	
F0000	INITIAL COMMENTS On 7/7/25 through 7/9/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			07/29/2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must		F0641	Upon discovery of the deficient practice, the MDS nurse immediately completed Resident R10's discharge assessment and submitted it to IQIES on July 10, 2025. For R12, R12 was sent to the hospital on 1/27/25. As a result of this hospitalization, a discharge return anticipated MDS was completed on 1/27/25. R12 did not return to the facility following the 1/27/25 hospitalization. To ensure no other residents were affected, audits were conducted on all residents discharged within the past		08/18/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0641 SS = D	Continued from page 1 conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a discharge Minimum Data Set (MDS) was completed and submitted to the Centers for Medicare and Medicaid (CMS) database as directed for 2 of 2 residents (R10, R12) reviewed for resident assessment task. Findings include: R10: R10's face sheet printed on 7/9/25, identified R10 was admitted on 1/15/25, and discharged on 2/25/25. R10's progress notes dated 1/13/25, identified R10 was admitted after a hospitalization from 12/30/24 through 1/13/25, due to respiratory failure, pneumonia and influenza. R10 was admitted on 1/13/25, for a short-term rehab stay and had planned to return to home. During R10's nursing home admission the resident	F0641	Continued from page 1 60 days. These audits confirmed that appropriate discharge MDS assessments had been completed in accordance with regulatory requirements. Education was provided to both the primary and secondary MDS nurses to reinforce the importance of timely and accurate completion of discharge MDS assessments in alignment with state regulations and the Resident Assessment Instrument (RAI) manual. To ensure ongoing compliance, the DON or designee will complete weekly audits for eight weeks, reviewing all resident discharges that occurred within each week to verify the accuracy and timeliness of MDS submissions. The QAPI committee will review audit findings, monitor for continued compliance, and address any emerging patterns or concerns related to MDS discharge documentation.	

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F0641 SS = D	Continued from page 2 received physical and occupational therapy for activities of daily living (ADL's), fall monitoring, pain monitoring, respiratory and medication management. R10's progress note dated 1/28/25 identified social services met with R10 regarding discharge planning and resident hoped to discharge home after rehab stay was complete. R10's progress notes dated 2/24/25, identified R10 would be discharged to home with in-home services on 2/25/25. R10's medical record lacked evidence there was a discharge MDS initiated, completed and submitted. R12: R12's undated face sheet, identified R12 was readmitted on 11/4/25, and discharged on 2/11/25. R12's entry tracking record MDS dated 1/23/25, identified R12 was re-admitted on 1/23/25, from a short-term general hospital. R12's quarterly MDS dated 1/27/25, identified the quarterly MDS was the first assessment since R12's most recent admission on 1/23/25, and R12 was readmitted from a short-term general hospital. There was no discharge date on the assessment. R12's nursing home progress note(s) identified the following:1/23/25, identified R12 was admitted after having an amputation of the left 3rd toe. R12 had orders for antibiotics, therapy and daily dressing changes. 1/27/25, identified writer called the primary care physician, discussed findings of dressing changes since admission, and concerns regarding possible infection. R12 was transferred to the emergency room. 2/11/25, identified writer received a call from R12 requesting the resident's daughter and other family members to come and pack up his belongings to bring to him. An update to the note identified per review of hospital case management notes, resident mentioned multiple times his desire to transfer to a different facility following hospitalization. Hospital notes were placed into scanning. Staff accepted the communication as resident-initiated discharge. 2/26/25 at 12:12 p.m., identified discharge summary and discharge notification was faxed to the hospital case manager.A joint interview was conducted with registered nurse (RN)-C		F0641				

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F0641 SS = D	Continued from page 3 and RN-D on 7/9/25 at 1:31 p.m. RN-C stated when a resident was transferred to an acute care setting and expected to stay greater than 24 hours, a discharge with anticipated return MDS would be completed. When a resident was discharged to home a discharge MDS would be completed and MDS's should be completed within one week. RN-C completed R12's discharge with anticipated return MDS dated 1/27/25, and mistakenly completed a quarterly MDS dated 1/27/25. RN-C should have completed a transmission error MDS for the quarterly MDS. R12 did not have a discharge MDS completed after resident was discharged from the nursing home on 2/11/25. RN-C failed to complete R10's discharge MDS. The assessment should have been completed by 2/25/258. The facility MDS/Resident Assessment policy signed 10/17/22, identified The MDS was completed for all residents in Medicare- or Medicaid-certified nursing homes. The facility will complete the MDS following the RAI manual and state requirements to assure each resident receives and accurate assessment that is reflective of each resident's status.	F0641		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	Upon discovery of the deficient practice, all identified staff members were immediately instructed to wear appropriate hair restraints when dishing and serving food to residents in the 400 unit. The DON or designee completed audits in all facility dining areas to assess compliance with hair coverings. No other incidents were found; however, continued auditing is in place to identify risks. Staff education has been given on the use of hair restraints while preparing meals. Education included use of hair net, hat, and scarves. This education was provided at the all staff meeting held on 7/31/25. Educational materials from MDS website were also provided to staff for review. The DON or designee will conduct audits in all dining rooms 5 times per week, starting on 7/21/25, for 4 weeks, then 2 times weekly for 2 months. Non-compliance will result in immediate staff education. The Quality Assurance and Performance Improvement (QAPI) committee will review and monitor for ongoing compliance. Date of compliance: 8/18/25	08/18/2025

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F0812 SS = E	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure staff dishing and serving food to residents wore a hairnet in 1 of 4 dining rooms (400-unit) with the potential to affect all residents who resided on the 400 unit. Findings include: The undated facility census identified 8 residents resided on the 400-unit. During observation on 7/8/25 at 5:00 p.m., a staff member wheel a steam table onto the 400-unit dining area. Seven residents were seated at tables in the dining room and one resident was eating in the their room. Trained medication aide (TMA)-A was wearing gloves and without a hair net dished food from the steam table onto a plate and then delivering the plate to a resident. TMA-A continued dishing and delivering food until all residents in the dining room had plates of food in front of them. On 7/8/25 at 5:19 p.m., TMA-A stated when she worked on the 400 unit she worked as a nursing assistant and a TMA, and always dished and delivered food to the residents. There was not a dietary staff member that assisted during meals. TMA-A never wore or thought about wearing a hair net while dishing food from the steam table and had not been told to wear a hair net while dishing food. TMA-A stated it was important to wear a hair net while dishing food to prevent hair from falling into the resident's food and potentially spreading any bacteria from her hair. On 7/9/25 at 9:10 a.m., registered nurse (RN)-A, who was also the infection control nurse, stated dietary staff dished food from the steam table and serve to residents in the 100-unit and 200-unit dining room(s) and nursing staff dished food from the steam table and serve to the residents in the 300-unit and 400-unit dining rooms. All staff, including nursing staff, were required to wear gloves and hair net when serving food from the steam cart. All staff were educated and knew they were required to wear hair nets. RN-A stated wearing hair nets helped prevent hair from falling into the food and potentially preventing the spread of bacteria from hair and into the food. The undated facility Infection Control for the Dietary		F0812				

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F0812 SS = E	Continued from page 5 Department policy, identified dietary staff would practice proper food handling procedures, including hand washing, wearing hairnets or caps and clean uniforms, as well as practice proper food handling procedures, including wearing hair nets or caps. The facility Employee Hygiene for Food Safety policy dated 2023, identified all employees would wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. Section 2-402.11 of the FDA Food code dated 2017 identified "A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair." This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Upon discovery of the deficient practice, proper signage and PPE were placed outside R146's room indicating the need for EBP. Staff caring for R146 and R12 were also immediately re-educated on infection control practices and audits were initiated to monitor for compliance with proper use of PPE. To identify others at risk for this deficient practice, all resident charts have been audited to ensure those residents requiring EBP have the necessary PPE implemented. Any other residents currently on EBP were reviewed to ensure proper signage and PPE is available. The facility's Evidence-Based Precautions policy was reviewed and revised to align with current CDC and CMS guidelines. In-service education was provided to clinical staff on July 31, 2025, which covered the criteria for initiating EBP and the correct use of personal protective equipment (PPE). Additionally, online education modules were assigned to all staff on July 14, 2025. To ensure readiness, PPE stations—including gloves, gowns, and hand hygiene supplies—were inspected for adequacy and fully stocked outside resident rooms where EBP is required. Standardized signage was also placed outside applicable resident rooms to clearly indicate EBP requirements in accordance with CDC guidance. Monitoring efforts include EBP audits conducted by the DON or designee. Audits began on July 23, 2025, and will occur five times per week for one month.	08/25/2025

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F0880 SS = D	Continued from page 6 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) in accordance with		F0880	Continued from page 6 Thereafter, audits will continue three times per week for one month, then twice weekly for one month, and finally once weekly for one month. These audits assess both the initiation of EBP and the correct use of PPE. Immediate education on infection prevention and control practices will be provided if noncompliance is identified. The Quality Assurance and Performance Improvement (QAPI) committee will oversee ongoing compliance with EBP practices.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
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F0880 SS = D	Continued from page 7 Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 2 of 5 residents (R2, R146) reviewed for wounds and 1 of 1 resident (R2) reviewed for catheter. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R2: R2's quarterly Minimum Data Set (MDS) dated 5/21/25, identified R2 was cognitively intact, was dependent on staff for all activities of daily living (ADL's). R2 had an indwelling catheter, was at risk for pressure ulcers and had moisture associated skin damage (MASD). Interventions included pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, application of nonsurgical dressings and ointment to area's other than the feet. R2's diagnoses included multiple sclerosis (MS) and neurogenic bladder. R2's care plan reviewed 6/5/25, identified R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 had impaired mobility and was at risk for pressure ulcer/injury and was prone to periods of skin maceration due to chronic ulcer to buttock. R2's progress note dated 6/24/25, identified R2 had dressing changes to the coccyx area per wound care. R2's progress note dated 7/7/25, identified R2 the		F0880				

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F0880 SS = D	Continued from page 8 following: 10 x10 centimeters (cm) darkened area around the coccyx. 5.5 cm x 3.5 cm sheared open area that was red and draining mild amounts of serosanguinous drainage. 1 cm x 1.5 cm area in the center that was darkened red and bleeding mildly. Nurse made a call to the doctor with an update and questioned if current wound appointment for 7/25/25 should be moved up. Encouraged R2 to stay off buttocks as much as possible. R2's progress notes failed to identify if R2 was on EBP. On 7/7/25 at 11:30 a.m., R2's door was observed and there was a sign identifying R2 was on EBP and there was a cart with PPE. R2 stated staff did not always wear a gown when emptying the resident's catheter. On 7/8/25 at 2:40 p.m., upon entering R2's room nursing assistant (NA)-C was observed standing next to R2's bed with a water basin on the bedside table and a folded washcloth in her gloved hand and was not wearing a gown. NA-C was wiping R2's suprapubic catheter tubing. NA-C stated R2 liked to get freshened up mid-day and in the evening. NA-C finished wiping the catheter and started to wipe R2's peri area, turned R2 on her side and began to wipe R2's coccyx area. NA-C stated she had been off for a few days and was unaware that R2's coccyx area was open, although the wound continually opened and healed. NA-C applied barrier cream to R2's coccyx area and proceeded to apply powder to groin area. NA-C finished dressing and getting R2 comfortable, removed gloves, collected garbage and exited the room. During interview, NA-C stated she typically wore PPE when freshening up R2. Staff were instructed to wear PPE for catheter and wound care. NA-C stated she had worn PPE including a gown and gloves when she completed catheter cares and cleansing R2's peri area and coccyx area, then threw the gown and gloves in the garbage, washed hands and put on clean gloves. NA-C stated that was when the state agent (SA) entered the room. On 7/8/25 at 3:52 p.m., R2 stated she couldn't remember if NA-C was wearing a gown when completing catheter		F0880				

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F0880 SS = D	Continued from page 9 care just recently, although staff hadn't always worn gowns while completing catheter or wound cares. Further, R2 stated it was important for staff to wear gowns, so they didn't spread infections her. R146: R146's entry tracking record MDS dated 6/30/25, identified R146 was admitted on 6/60/25. R146's undated Resident Face Sheet included diagnoses of sepsis (serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death), malignant neoplasm of colon, diabetes, congestive heart failure and bullous pemphigoid (rare skin condition that causes large fluid-filled blisters). R14's progress notes were reviewed from 6/30/25 to 7/8/25 and identified the following: 6/30/25, an admission note identified R146 had scaly darkened skin on both her lower legs, which was a chronic issue for R146. R146 did have a history of open areas to her lower legs, however were not open on admission. 7/2/25, skin note: an open area was noted on anterior shin of left leg that measured 5 cm length by 4.5 cm wide. The area was cleansed and antibiotic ointment was applied. 7/3/25, weeping was noted on both lower extremities. Legs were cleansed and triple antibiotic ointment applied. An abdominal pad was applied and legs were wrapped with a gauze roll. 7/4/25, R146's legs had weeping with a moderate amount of serosanguinous drainage. R146's legs were cleansed with normal saline, dressing were applied, covered with abdominal pad and wrapped with a gauze roll. R146's treatment administration record was updated to reflect the dressing change. During observation on 7/7/25, at 1:30 p.m. licensed practical nurse (LPN)-A gathered dressing supplies and entered R146's room to change the leg dressings on R146's right and left legs. There was no signage or		F0880				

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F0880 SS = D	Continued from page 10 personal protective equipment cart set up near or in R146's room to identify if R146 required any type of precautions. R146 was lying in bed, visiting with three family members. LPN-A notified R146 and her family she was going to perform dressing changes to R146 wounds on her right and left calves and they could remain in the room, seated in chairs at the foot of R146's bed if they wished to. All three family members agreed to stay. LPN-A placed her dressing supplies on R146's window sill and went to the resident bathroom and washed her hands. LPN-A then put on gloves and started to remove the old dressing from R146's left leg. LPN-A stopped and put on R146's call light to request another staff member to assist her. Nursing assistant (NA)-A entered the room. NA-A was wearing a face mask and when asked to assist with the dressing change, washed her hands and put on gloves. LPN-A removed R146's old dressing from her left leg as NA-A held the leg up off R146's bed, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down and raised up R146's right leg. LPN-A changed her gloves and removed the old dressing from R146's right leg, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. A large 2 centimeter clear fluid filled blister was formed on the inner side of the wound. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down. LPN-A gathered up and disposed of the dressings in the resident's garbage, removed her gloves and exited the room. NA-A removed her gloves, washed her hands and exited the room. On 7/8/25, at 8:00 a.m. an EBP sign and personal protective equipment (PPE) cart was observed hanging on the outside of R146's room door. During interview on 7/8/25, at 8:30 a.m. LPN-A stated R146 should have been on EBP, but she had not been aware R146's wounds were open until she had performed wound care on 7/7/25. After performing wound care on 7/7/25, LPN-A notified the facility's registered nurse and they set up the PPE and signage. LPN-A stated she and NA-A should have been wearing a disposable gown as		F0880				

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F0880 SS = D	Continued from page 11 well as gloves to perform the wound care but they had not. When interviewed on 7/8/25, at 9:05 a.m. NA-A stated she should have been wearing a disposable gown when she had assisted LPN-A with R146's wound care. NA-A had been off for a few days and had not worked with R146 before. When she entered the room and they started removing R146's dressings she knew they should have donned gowns for the wound care but they were already into it and so just completed it and then NA-A went directly to the RN on and notified her of the open areas and need for PPE. The RN had not been aware the wounds were open and then they immediately setup the room for PPE and precautions. During interview on 7/8/25, at 10:30 a.m. the infection control registered nurse (RN)-A stated the facility initiated EBP for all residents with a urinary catheter, wound care, dressings, any invasive lines, and feeding tubes. RN-A reviewed all new admissions for invasive lines or wounds and usually had EBP precautions and signage setup before new admission arrived to the facility. If existing residents had changes or new open areas she usually noted it by reading the shift report notes or the nurse responsible would notify her, or the NA's if they notice something when doing resident cares. R146's legs did not have open areas present when she was admitted. As soon as she was notified of the open areas, she immediately initiated EBP. RN-A On 7/8/25 at 4:17 p.m., the director of nursing (DON) stated staff were required to wear PPE, including gown and gloves, when completing direct patient care including working with indwelling medical devices or open wounds, and were expected to change gloves from dirty to clean, including before applying barrier cream and/or powders. Staff should not complete catheter care or wound care without wearing PPE. The Facility Enhanced Barrier Precautions policy dated 4/1/24, identified EBP would be utilized for high-risk residents during high contact care and activities to aide in the prevention of MDRO spread. Residents would be assessed ... for indwelling medical devices (i.e.: urinary catheters) and for wounds that may require EBP. If a residents require any indwelling medical devices or meet the CDC wound requirements, they will be placed on EBP. EBP will be used for selected resident's wit high contact care and activity per CDC guidelines. EBP		F0880				

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

FORM APPROVED
OMB NO. 0938-0391

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F0880 SS = D	Continued from page 12 signs would be placed on the resident room doors to identify PPE required as well as defining high risk resident activities. Gowns, gloves and alcohol-based hand rub (ABHR) will be available to staff in EBP rooms. Gown and gloves will be donned prior to the high contact activity; they do not have to be donned prior to entering room. Gown and gloves will be doffed as well as hand hygiene completed prior to leaving the resident room or between care of residents in shared room.			F0880			

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/10/2025. At the time of this survey, Cornerstone Nursing & Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:		K0000			07/30/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction. The 1968 building was completely remodeled at that time. The two types of construction are not separated by a 2 hour fire barrier but meets all the requirements to be surveyed as one, type V (111) building. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 47 beds and had a census of 43 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:		K0000				
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA		K0324	This citation was issued in error, based on the incorrect assumption that the facility's stove/oven is gas-powered. The State Fire Marshal confirmed that the citation is not valid if the appliance is electric. The facility verifies that the stove/oven in question is an electric appliance.		08/01/2025	

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K0324 SS = F	Continued from page 2 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 07/10/2025 at 10:24am, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Continued from page 2 This clarification has been documented in the facility's Life Safety records for future reference.		
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101			K0353	During a recent inspection, a storage rack was found not secured to the wall, resulting in non-compliance with required overhead clearance for sprinkler systems. The rack was immediately fastened to meet code		08/08/2025

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K0353 SS = D	Continued from page 3 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 07/10/2025 at 10:11am, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in storage room 100. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0353	Continued from page 3 requirements. The Environmental Services Director completed a facility-wide audit of all storage areas, including closets and supply rooms. All shelving within 18 inches of the ceiling was confirmed to be either properly secured or adjusted to meet code. To prevent recurrence, Department Heads were reeducated on NFPA clearance standards and signed acknowledgment of training. The Environmental Services Director will conduct monthly audits of storage areas using a checklist added to the preventive maintenance log. Audit results will be reviewed quarterly by the Safety Committee and QAPI to ensure ongoing compliance and identify any concerns.			
K0761 SS = D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors		K0761	Following the surveyor's observation, maintenance staff inspected the 2 hour fire-rated door frame leading to the assisted living facility and found that tape had been placed over the manufacturer's rating label. The tape was removed, and the label was confirmed to be		08/08/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/10/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
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K0761 SS = D	Continued from page 4 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/10/2025 at 10:26am, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. 1) Fire doors leading to Senior living Wing / door 200 Dining Room An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0761	Continued from page 4 intact and legible. A facility-wide inspection of all 2-hour fire-rated doors and frames was completed to ensure no other labels were obstructed. All were found to be present, intact, and legible. To prevent recurrence, the annual door inspection log was revised to include verification of visible, unobstructed rating labels on all 2-hour fire-rated doors and frames. This item was also added to the preventive maintenance log for tracking. Compliance will be monitored through annual door inspections, and results will be reviewed during QAPI to ensure ongoing oversight.			
K0912 SS = E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a		K0912	During the Life Safety Code survey, a non-approved multi-plug receptacle was found in use by the facility's telephone vendor during installation of a new phone system. The device was immediately removed and replaced with an approved outlet. Following this, the Environmental Services Director completed a facility-wide audit to ensure no other non-compliant electrical devices were in use. To prevent recurrence, the telephone vendor was notified that only facility-approved electrical		08/11/2025	

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K0912 SS = E	Continued from page 5 listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, section 406.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/10/2025 at 10:08am, it was revealed by observation that there was an electrical junction box in the ceiling for the new phone system with a multi-plug device. These multi-plug devices are not aloud in healthcare facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0912	Continued from page 5 equipment may be used during installations. The Environmental Services Director will review future telephone system work to ensure compliance, and maintenance staff have been instructed to report any unapproved devices immediately for removal. Quarterly audits will be conducted to monitor for unapproved electrical items. A tracking sheet has been added to the preventive maintenance log, and results will be reviewed during QAPI.	
K0918 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K0918	The required 36-month, 4-hour load bank test was completed on 11/30/2023 by Ziegler. However, documentation was not available during the survey due to a filing oversight. The Environmental Services Director has since obtained the test report and filed it correctly in the 2023 generator maintenance records. To ensure all documentation is properly maintained, an audit of all generator maintenance paperwork was conducted. This audit confirmed that all other required documents are properly filed and accessible. A dedicated section for load bank test documentation has been created in the generator maintenance log for easier access. The Maintenance Director has been re-educated on maintaining and promptly locating required documentation during surveys. For ongoing monitoring, the Administrator or designee will verify annually that load bank test records are completed, properly filed, and accessible. This will be documented on an annual audit form and reviewed during QAPI to ensure continued compliance.	08/11/2025

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K0918 SS = D	Continued from page 6 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/10/2025 at 09:15am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0918				
K0920 SS = F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a		K0920	Upon discovery of the deficient practice, any unapproved items that had been plugged into a power strip were immediately removed. To ensure this issue was not widespread, the Environmental Services Director conducted a comprehensive audit of all offices and common areas to verify that no other unapproved items were inappropriately connected to surge protectors. To prevent recurrence, a new checklist has been implemented to support ongoing monitoring and documentation of the proper use of surge protectors. This checklist has been added to the preventive maintenance binder, housed in the Environmental Services office. Beginning July 25, 2025, the Environmental Services Director or designee will conduct monthly audits of all offices and communal areas for a full calendar year.		08/11/2025	

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K0920 SS = F	Continued from page 7 structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/10/2025 at 10:19am, it was revealed by observation that there were electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; Power-strip in infection control office An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0920	Continued from page 7 Findings from these audits will be reviewed during QAPI meetings to ensure continued compliance and identify any necessary improvements.			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 29, 2025

Administrator

Cornerstone Nsg & Rehab Center

416 SEVENTH STREET NORTHEAST

BAGLEY, MN 56621

Re: State Nursing Home Licensing Orders

Event ID: UVR411

Dear Administrator:

On July 9, 2025 a survey was completed 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
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20000	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: On 7/7/25 through 7/9/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			07/29/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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20000	Continued from page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. 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.		20000				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a discharge Minimum Data Set (MDS) was completed and submitted to the Centers for Medicare and Medicaid (CMS) database as directed for 2 of 2 residents (R10, R12) reviewed for resident assessment task.		20550	Corrected.		08/06/2025	

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20550	Continued from page 2 Findings include: R10: R10's face sheet printed on 7/9/25, identified R10 was admitted on 1/15/25, and discharged on 2/25/25. R10's progress notes dated 1/13/25, identified R10 was admitted after a hospitalization from 12/30/24 through 1/13/25, due to respiratory failure, pneumonia and influenza. R10 was admitted on 1/13/25, for a short-term rehab stay and had planned to return to home. During R10's nursing home admission the resident received physical and occupational therapy for activities of daily living (ADL's), fall monitoring, pain monitoring, respiratory and medication management. R10's progress note dated 1/28/25 identified social services met with R10 regarding discharge planning and resident hoped to discharge home after rehab stay was complete. R10's progress notes dated 2/24/25, identified R10 would be discharged to home with in-home services on 2/25/25. R10's medical record lacked evidence there was a discharge MDS initiated, completed and submitted. R12: R12's undated face sheet, identified R12 was readmitted on 11/4/25, and discharged on 2/11/25. R12's entry tracking record MDS dated 1/23/25, identified R12 was re-admitted on 1/23/25, from a short-term general hospital. R12's quarterly MDS dated 1/27/25, identified the quarterly MDS was the first assessment since R12's most recent admission on 1/23/25, and R12 was readmitted from a short-term general hospital. There was no discharge date on the assessment. R12's nursing home progress note(s) identified the following:1/23/25, identified R12 was admitted after having an amputation of the left 3rd toe. R12 had orders for antibiotics, therapy and daily dressing changes.1/27/25, identified writer called the primary care physician, discussed findings of dressing changes		20550				

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20550	Continued from page 3 since admission, and concerns regarding possible infection. R12 was transferred to the emergency room.2/11/25, identified writer received a call from R12 requesting the resident's daughter and other family members to come and pack up his belongings to bring to him. An update to the note identified per review of hospital case management notes, resident mentioned multiple times his desire to transfer to a different facility following hospitalization. Hospital notes were placed into scanning. Staff accepted the communication as resident-initiated discharge.2/26/25 at 12:12 p.m., identified discharge summary and discharge notification was faxed to the hospital case manager.A joint interview was conducted with registered nurse (RN)-C and RN-D on 7/9/25 at 1:31 p.m. RN-C stated when a resident was transferred to an acute care setting and expected to stay greater than 24 hours, a discharge with anticipated return MDS would be completed. When a resident was discharged to home a discharge MDS would be completed and MDS's should be completed within one week. RN-C completed R12's discharge with anticipated return MDS dated 1/27/25 and mistakenly completed a quarterly MDS dated 1/27/25. RN-C should have completed a transmission error MDS for the quarterly MDS. R12 did not have a discharge MDS completed after resident was discharged from the nursing home on 2/11/25. RN-C failed to complete R10's discharge MDS. The assessment should have been completed by 2/25/258. The facility MDS/Resident Assessment policy signed 10/17/22, identified The MDS was completed for all residents in Medicare- or Medicaid-certified nursing homes. The facility will complete the MDS following the RAI manual and state requirements to assure each resident receives and accurate assessment that is reflective of each resident's status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review the RAI manual, review policies and procedures to ensure timely and accurate completion of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary		21375	Corrected.		08/06/2025	

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21375	Continued from page 4 environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 2 of 5 residents (R2, R146) reviewed for wounds and 1 of 1 resident (R2) reviewed for catheter. Based on observation, interview and document review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 2 of 5 residents (R2, R146) reviewed for wounds and 1 of 1 resident (R2) reviewed for catheter. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R2: R2's quarterly Minimum Data Set (MDS) dated 5/21/25, identified R2 was cognitively intact, was dependent on staff for all activities of daily living (ADL's). R2 had an indwelling catheter, was at risk for pressure ulcers and had moisture associated skin damage (MASD). Interventions included pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, application of nonsurgical dressings and ointment to area's other than the feet. R2's diagnoses included multiple sclerosis (MS) and neurogenic bladder.		21375				

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21375	Continued from page 5 R2's care plan reviewed 6/5/25, identified R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 had impaired mobility and was at risk for pressure ulcer/injury and was prone to periods of skin maceration due to chronic ulcer to buttock. R2's progress note dated 6/24/25, identified R2 had dressing changes to the coccyx area per wound care. R2's progress note dated 7/7/25, identified R2 the following:10 x10 centimeters (cm) darkened area around the coccyx. 5.5 cm x 3.5 cm sheared open area that was red and draining mild amounts of serosanguinous drainage. 1 cm x 1.5 cm area in the center that was darkened red and bleeding mildly. Nurse made a call to the doctor with an update and questioned if current wound appointment for 7/25/25 should be moved up. Encouraged R2 to stay off buttocks as much as possible.R2's progress notes failed to identify if R2 was on EBP. On 7/7/25 at 11:30 a.m., R2's door was observed and there was a sign identifying R2 was on EBP and there was a cart with PPE. R2 stated staff did not always wear a gown when emptying the resident's catheter. On 7/8/25 at 2:40 p.m., upon entering R2's room nursing assistant (NA)-C was observed standing next to R2's bed with a water basin on the bedside table and a folded washcloth in her gloved hand and was not wearing a gown. NA-C was wiping R2's suprapubic catheter tubing. NA-C stated R2 liked to get freshened up mid-day and in the evening. NA-C finished wiping the catheter and started to wipe R2's peri area, turned R2 on her side and began to wipe R2's coccyx area. NA-C stated she had been off for a few days and was unaware that R2's coccyx area was open, although the wound continually opened and healed. NA-C applied barrier cream to R2's coccyx area and proceeded to apply powder to groin area. NA-C finished dressing and getting R2 comfortable, removed gloves, collected garbage and exited the room. During interview, NA-C stated she typically wore PPE when freshening up R2. Staff were instructed to wear PPE for catheter and wound care. NA-C stated she had worn PPE including a gown and gloves when she completed catheter cares and cleansing R2's peri area and coccyx area, then threw the gown and gloves in the garbage, washed hands and put on clean gloves. NA-C stated that was when the state agent (SA)		21375				

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21375	Continued from page 6 entered the room. On 7/8/25 at 3:52 p.m., R2 stated she couldn't remember if NA-C was wearing a gown when completing catheter care just recently, although staff hadn't always worn gowns while completing catheter or wound cares. Further, R2 stated it was important for staff to wear gowns, so they didn't spread infections her. R146: R146's entry tracking record MDS dated 6/30/25, identified R146 was admitted on 6/60/25. R146's undated Resident Face Sheet included diagnoses of sepsis (serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death), malignant neoplasm of colon, diabetes, congestive heart failure and bullous pemphigoid (rare skin condition that causes large fluid-filled blisters). R14's progress notes were reviewed from 6/30/25 to 7/8/25 and identified the following:6/30/25, an admission note identified R146 had scaly darkened skin on both her lower legs, which was a chronic issue for R146. R146 did have a history of open areas to her lower legs, however were not open on admission.7/2/25, skin note: an open area was noted on anterior shin of left leg that measured 5 cm length by 4.5 cm wide. The area was cleansed and antibiotic ointment was applied.7/3/25, weeping was noted on both lower extremities. Legs were cleansed and triple antibiotic ointment applied. An abdominal pad was applied and legs were wrapped with a gauze roll.7/4/25, R146's legs had weeping with a moderate amount of serosanguinous drainage. R146's legs were cleansed with normal saline, dressing were applied, covered with abdominal pad and wrapped with a gauze roll. R146's treatment administration record was updated to reflect the dressing change.During observation on 7/7/25, at 1:30 p.m. licensed practical nurse (LPN)-A gathered dressing supplies and entered R146's room to change the leg dressings on R146's right and left legs. There was no signage or personal protective equipment cart set up near or in R146's room to identify if R146 required any type of precautions. R146 was lying in bed, visiting with three family members. LPN-A notified R146 and her family she was going to perform dressing changes to R146 wounds on her right and left calves and they could		21375				

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21375	Continued from page 7 remain in the room, seated in chairs at the foot of R146's bed if they wished to. All three family members agreed to stay. LPN-A placed her dressing supplies on R146's window sill and went to the resident bathroom and washed her hands. LPN-A then put on gloves and started to remove the old dressing from R146's left leg. LPN-A stopped and put on R146's call light to request another staff member to assist her. Nursing assistant (NA)-A entered the room. NA-A was wearing a face mask and when asked to assist with the dressing change, washed her hands and put on gloves. LPN-A removed R146's old dressing from her left leg as NA-A held the leg up off R146's bed, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down and raised up R146's right leg. LPN-A changed her gloves and removed the old dressing from R146's right leg, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. A large 2 centimeter clear fluid filled blister was formed on the inner side of the wound. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down. LPN-A gathered up and disposed of the dressings in the resident's garbage, removed her gloves and exited the room. NA-A removed her gloves, washed her hands and exited the room. On 7/8/25, at 8:00 a.m. an EBP sign and personal protective equipment (PPE) cart was observed hanging on the outside of R146's room door. During interview on 7/8/25, at 8:30 a.m. LPN-A stated R146 should have been on EBP, but she had not been aware R146's wounds were open until she had performed wound care on 7/7/25. After performing wound care on 7/7/25, LPN-A notified the facility's registered nurse and they set up the PPE and signage. LPN-A stated she and NA-A should have been wearing a disposable gown as well as gloves to perform the wound care but they had not. When interviewed on 7/8/25, at 9:05 a.m. NA-A stated she should have been wearing a disposable gown when she		21375				

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21375	Continued from page 8 had assisted LPN-A with R146's wound care. NA-A had been off for a few days and had not worked with R146 before. When she entered the room and they started removing R146's dressings she knew they should have donned gowns for the wound care but they were already into it and so just completed it and then NA-A went directly to the RN on and notified her of the open areas and need for PPE. The RN had not been aware the wounds were open and then they immediately setup the room for PPE and precautions. During interview on 7/8/25, at 10:30 a.m. the infection control registered nurse (RN)-A stated the facility initiated EBP for all residents with a urinary catheter, wound care, dressings, any invasive lines, and feeding tubes. RN-A reviewed all new admissions for invasive lines or wounds and usually had EBP precautions and signage setup before new admission arrived to the facility. If existing residents had changes or new open areas she usually noted it by reading the shift report notes or the nurse responsible would notify her, or the NA's if they notice something when doing resident cares. R146's legs did not have open areas present when she was admitted. As soon as she was notified of the open areas, she immediately initiated EBP. RN-A On 7/8/25 at 4:17 p.m., the director of nursing (DON) stated staff were required to wear PPE, including gown and gloves, when completing direct patient care including working with indwelling medical devices or open wounds, and were expected to change gloves from dirty to clean, including before applying barrier cream and/or powders. Staff should not complete catheter care or wound care without wearing PPE. The Facility Enhanced Barrier Precautions policy dated 4/1/24, identified EBP would be utilized for high-risk residents during high contact care and activities to aide in the prevention of MDRO spread. Residents would be assessed ... for indwelling medical devices (i.e.: urinary catheters) and for wounds that may require EBP. If a residents require any indwelling medical devices or meet the CDC wound requirements, they will be placed on EBP. EBP will be used for selected resident's wit high contact care and activity per CDC guidelines. EBP signs would be placed on the resident room doors to identify PPE required as well as defining high risk resident activities. Gowns, gloves and alcohol-based hand rub (ABHR) will be available to staff in EBP rooms. Gown and gloves will be donned prior to the high contact activity; they do not have to be donned prior		21375				

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21375	Continued from page 9 to entering room. Gown and gloves will be doffed as well as hand hygiene completed prior to leaving the resident room or between care of residents in shared room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review revise policies and procedures on enhanced barrier precautions, educate staff on requirements and audit cares with residents on EBP to ensure compliance and take the results of those audits to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.		21375				