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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UW9B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00974

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

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

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

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

6. DATE OF SURVEY **07/25/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 08/08/2016
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/16/2016
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/19/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245307

September 19, 2016

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

Dear Ms. Swanson:

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

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

Effective July 11, 2016 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 8, 2016

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

RE: Project Number S5307026

Dear Ms. Swanson:

On June 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016. 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 July 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 2016 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 June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective July 11, 2016 and therefore remedies outlined in our letter to you dated June 22, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245307 Y1	A. Building B. Wing Y2	7/25/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix F0502	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(j)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	08/08/2016	28035	07/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/9/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245307	A. Building 01 - MAIN BUILDING B. Wing	7/18/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 07/01/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 07/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 08/08/2016	**SIGNATURE OF SURVEYOR** 36536	**DATE** 07/18/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/7/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245307 Y1	A. Building 02 - 2015 ADDITION B. Wing Y2	7/18/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0025	07/01/2016	LSC	K0050	07/01/2016	LSC	K0062	07/01/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0075	07/01/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TTL/mm	08/08/2016	36536	07/18/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/7/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UW9B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00974

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

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

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

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

6. DATE OF SURVEY **06/09/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Yvonne Switajewski, HFE NEII — 07/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 07/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5307

On June 9, 2016, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.This survey found the most serious deficiencies in the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. In addition, at the time of the June 9, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5307013 that was found to be unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction. Post Certificatoin Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 22, 2016

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

RE: Project Number S53070256 and H5307013

Dear Ms. Swanson:

On June 9, 2016, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 9, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5307013 that was found to be unsubstantiated.

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

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

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:

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

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 July 19, 2016, 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 July 19, 2016 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 September 9, 2016 (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 December 9, 2016 (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
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. Investigation of complaint H5307013 was also completed. The complaint was not substantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided as directed by the care plan for 1 of 3 residents (R68) who required assistance with oral hygiene and was not provided the assistance. The facility also failed to ensure repositioning and incontinence care was provided as directed by the care plan for 1 of 3 residents	F 282	Cornerstone Nursing and Rehab Center strives to provide and arrange for services provided by qualified persons in accordance with each resident□s written plan of care. Education and revisions have been made to assure that this is being accomplished. R6, care plan was reviewed for	7/11/16

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

Electronically Signed | 06/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 (R6) identified at risk for pressure ulcers and was incontinent or bowel/bladder and dependent on staff for these services. Findings include: R68 was not provided assistance with oral hygiene as directed by the care plan. R68's Care Plan dated 4/2/16, indicated R68 required assist of one staff to complete oral hygiene. On 6/8/16, at 7:30 am. nursing assistant (NA)-D was observed to provide R68 morning cares. During the observation, NA-D was observed to place R68's upper denture and lower partial into R68's mouth without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-D assisted R68 into a wheelchair and wheeled R68 out of the room. At no time did NA-D offer R68 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/8/16, at 8:55 a.m. NA-D verified oral hygiene was not completed prior to inserting R68's dentures. NA-D stated she usually utilized a mint flavored mouth swab to cleanse R68's mouth, however, she had forgot to. On 6/9/16, at 9:05 a.m. the director of nursing (DON) verified R68's care plan and stated oral hygiene should have been provided, as directed. The undated facility Brushing Teeth policy, indicated a resident should be assisted with	F 282	repositioning and incontinence schedules on 6/25/16 and were current. Facility policies and documentation systems were reviewed on 6/25/16, with updates made. Nursing staff to attend a mandatory in-service on 6/20/16 and 7/6/16, which addressed the importance of following care plans and review updated policies. R68, care plan was reviewed for oral hygiene on 6/25/16 and were current. Facility policies and documentation systems were reviewed on 6/25/16, with updates made as necessary. Nursing staff to attend a mandatory in-service on 6/20/16 and 7/6/16, to address the importance of following care plans. The Director of Nursing or designee shall complete weekly random audits of repositioning, toileting, and oral hygiene of residents for 3 weeks and quarterly for 6 months to ensure compliance continues to be met or until compliance is reached. Results of these audits will be reported at the facility QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 brushing his or her teeth based on his or her individual needs. R6 did not receive repositioning assistance or bowel incontinence care as directed by the care plan for three hours and 18 minutes on 6/8/16. R6's Care Plan dated 3/22/16, directed one-two staff to turn and reposition and check and change incontinent brief every two hours in an attempt to preserve skin integrity. On 6/8/16, at 7:52 a.m. NE-E was observed to enter R6's room and proceed to provide morning cares. At 8:07 a.m. following the completion of cares, NE-E and NA-A assisted R6 into the wheelchair and wheeled R6 near the dining room. R6 was continuously observed following the provision of morning cares. -At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. -At 9:28 a.m. NA-B wheeled R6 to the hallway where he remained until 9:45 a.m. -At 9:45 a.m. NA-A wheeled R6 to room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m. -At 11:20 a.m. NA-A stated they had not been able to check, change or reposition R6 since he got up in the morning. NA-A also stated it was R6's bath day and they were not able to do anything until his bed had been washed. -At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was observed to be dry of urine, however, R6 had been incontinent of stool. NA-A changed R6's	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 incontinent brief and provided perianal care. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should have been checked, changed and repositioned every two hours and had not been since he was assisted up in the morning. (3 hours and 18 minutes earlier) On 6/8/16, at 1:04 p.m. NA-A stated if R6 was combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not reapproached R6 and he had gone 3 hours and 18 minutes without repositioning, offloading or check/change for incontinence. On 6/9/16, at 8:36 a.m. the DON confirmed R6 should have been repositioned/offloaded and incontinent brief checked/changed every two hours as directed on his care plan. The undated Using the Care Plan policy indicated the care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had responsibility for providing care or services to the resident.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 4 by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided for 1 of 3 residents (R68) who required assistance with oral hygiene. In addition, the facility failed to ensure bowel incontinence care was provided for 1 of 3 resident (R6) who was dependent on staff for assistance. Findings include: R68 was not provided oral hygiene on the morning of 6/8/16, as directed by the care plan. R68's initial Minimum Data Set (MDS) dated 4 /9/16, indicated R68 had diagnoses of dementia, chronic obstructive disease (COPD), and diabetes. The MDS also indicated R68 had impaired cognition and required extensive assistance for mobility, dressing and personal hygiene. The MDS further indicated R68 had no dental concerns. R68's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 4/13/16, indicated R68 required extensive assistance with dressing, grooming, and physical assistance with bathing due to impaired balance with transfers and ambulation, had a recent hospitalization with increased confusion and weakness. R68's Care Plan dated 4/2/16, indicated R68 required assist of one staff to complete oral hygiene. On 6/8/16, at 7:30 am. nursing assistant (NA)-D was observed to provide R68 morning cares. During the observation, NA-D was observed to	F 312	Cornerstone Nursing and Rehab Center strives to provide residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Education and processes have been addressed to assure that this happens. R6, care plan was reviewed for incontinence schedules on 6/25/16 and were current. Facility policies and documentation systems were reviewed on 6/25/16, new policy on fecal incontinence was written. Nursing staff to attend a mandatory in-service on 6/20/16 and 7/6/2016, which addressed the importance of following care plans and to go over updated policies. R68, care plan was reviewed for oral hygiene on 6/25/16 and were current. Facility policies and documentation systems were reviewed on 6/25/16, with updates were made as necessary. Nursing staff to attend a mandatory in-service on 6/20/16 and 7/6/2016, which will address the importance of following care plans. The Director of Nursing or designee shall complete daily random audits of toileting and oral hygiene of residents for 3 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 5	F 312		

place R68's upper denture and lower partial into R68's mouth without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-D assisted R68 into a wheelchair and wheeled R68 out of the room. At no time did NA-D offer R68 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures.

On 6/8/16, at 8:55 a.m. NA-D verified oral hygiene was not completed prior to inserting R68's dentures. NA-D stated she usually utilized a mint flavored mouth swab to cleanse R68's mouth, however, she forgot to.

On 6/9/16, at 9:05 a.m. the director of nursing (DON) verified R68's care plan was correct and stated oral hygiene should have been provided, as directed.

The undated, facility Mouth Care policy indicated the purpose of mouth care was to keep the resident's lips and oral tissue moist, to cleanse and freshen the resident's mouth, and prevent infections of the mouth.

The undated facility Brushing Teeth policy indicated a resident should be assisted with brushing his or her teeth based on his or her individual needs.

R6 did not receive bowel incontinence care for three hours and 18 minutes on 6/8/16.

R6's annual MDS dated 3/20/16, indicated R6 had severely impaired cognition and diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 6	F 312		

which included paranoid schizophrenia, contracture (fixed high resistance to passive stretch of a muscle), glaucoma and chronic obstructive pulmonary disease. The MDS indicated R6 required extensive assistance of two staff for bed mobility, was totally dependent upon two staff for transfer and toilet use and was totally dependent upon one staff member for personal hygiene. The MDS further indicated R6 was always incontinent of bowel and bladder and did not participate in a toileting program to manage continence.

R6's Urinary Incontinence and Indwelling Catheter CAA dated 3/22/16, indicated R6 was incontinent of bowel and bladder and required assistance with toileting and bed mobility. The CAA indicated R6 wore incontinence products at all times and was able to alert staff to the urge of a bowel movement once during the MDS assessment period however most times he was incontinent. The CAA indicated R6's cognition was severely impaired and he was not a candidate for bowel/bladder training. The CAA further indicated nursing would continue to check/change and toilet R6 as requested, at least every 2 hours, in conjunction with an offloading schedule in an attempt to maintain skin integrity and decrease incontinent episodes.

R6's Care Plan dated 3/22/16, indicated staff must anticipate all R6's cares/needs. The plan indicated R6 was incontinent of bowel and bladder and would rarely alert staff of needs. The plan futher indicated R6 was not a candidate for toilet training related to poor cognition and directed staff to check and change R6 at least every two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 On 6/8/16, at 7:52 a.m. NA-E was observed to assist R6 with morning cares. -At 8:07 a.m. following the completion of morning cares, NA-A and NA-E transferred R6 into the wheelchair. R6 was then shaved and oral cares were offered. R6 was wheeled out of the room and placed in the hallway outside the dining room. Following the observation, R6 was continuously observed seated in his wheelchair. -At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. R6 was continuously observed seated in the dining room. -At 9:28 a.m. NA-B wheeled R6 to the hallway where he remained seated in the hallway until 9:45 a.m. -At 9:45 a.m. NA-A wheeled R6 to his room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m. -At 11:20 a.m. NA-A stated they had not been able to check, change or reposition R6 since he got up in the morning. NA-A stated it was R6's bath day and they were not able to do anything with him until his bed had been washed. -At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was observed to be dry of urine, however, R6 had been incontinent of stool. NA-A changed R6's incontinent brief and provided perianal care. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should be checked, changed and repositioned every two hours and he had not been since he got up in the morning. (3 hours and 18 minutes earlier) On 6/8/16, at 1:04 p.m. NA-A stated if R6 was	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not reapproached R6 and he had gone 3 hours and 18 minutes without incontinence care. On 6/9/16, at 8:36 a.m. the DON confirmed R6 should have been checked and incontinent product changed every two hours as directed on his care plan. No policy regarding bowel incontinence was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 3 residents (R6) identified at risk for the development of a pressure ulcer and required staff assistance to reposition.	F 314	Cornerstone Nursing and Rehab Center strives to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's condition demonstrates that they were unavoidable. A resident having pressure sores must receive	7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 Finding include: R6's annual Minimum Data Set (MDS) dated 3/20/16, indicated R6 was severely cognitively impaired and had diagnoses which included paranoid schizophrenia, contracture (fixed high resistance to passive stretch of a muscle), glaucoma and chronic obstructive pulmonary disease. The MDS indicated R6 required extensive assistance of two staff for bed mobility, was totally dependent upon two staff for transfers and toilet use and was totally dependent upon one staff member for personal hygiene. The MDS further indicated R6 was at risk for the development of a pressure ulcer and required a turning and repositioning program. R6's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 3/22/16, indicated R6 was at risk for the development of pressure ulcers. The CAA indicated nursing would continue to check/change and toilet R6 as requested, at least every two hours, in conjunction with an offloading schedule in an attempt to maintain skin integrity and decrease incontinent episodes. R6's Skin Risk Assessment with Braden Scale dated 3/18/16, indicated R6 was at risk for the development of a pressure ulcer and required pressure reducing devices for chair and bed and required a turning and repositioning program. R6's Tissue Tolerance Test dated 3/18/16, indicated R6 required staff assist with toileting needs every two hours and R6 would be repositioned, turned or offloaded in conjunction with toileting in attempt to maintain skin integrity.	F 314	necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. R6, care plan was reviewed for repositioning schedules on 6/25/16 and were current. Facility policies and documentation systems were reviewed on 6/25/16, with updates made. Nursing staff to attend a mandatory in-service on 6/20/16 and 7/6/16, which addressed the importance of following care plans and review updated policies. The Director of Nursing or designee shall complete weekly random audits of repositioning of residents for 3 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 R6's Care Plan dated 3/22/16, indicated staff must anticipate all R6's cares/needs. The Care Plan also indicated R6 had contractures in all extremities including deformed and contracted hands, especially the left and was unable to stand or ambulate safely. The Care Plan further indicated R6 required assistance of 1-2 staff to turn, reposition and offload and directed this be done every two hours and as needed. On 6/8/16, at 7:52 a.m. nursing assistant (NA)-E was observed to enter R6's room provide morning cares. R6's skin was observed without redness to bony prominences. R6 was observed to strike out and kick during cares. NA-E maintained a calm approach, explained what she was doing and redirected R6 when this occurred. R6 was dressed and a mechanical lift sling was placed under him. NA-A entered the room and R6 was transferred into a wheelchair at 8:07 a.m. R6 was shaved and oral cares were offered. R6 was then wheeled out of the room and placed in the hallway outside the dining room. R6 was continuously observed seated in his wheelchair in the hallway. -At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. R6 was continuously observed seated in the dining room. -At 9:28 a.m. NA-B wheeled R6 to the hallway and he remained seated in the hallway until 9:45 a.m. -At 9:45 a.m. NA-A wheeled R6 to room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m. -At 11:20 a.m. NA-A stated they had not been able to reposition R6 since he got up in the morning (3 hours and 18 minutes earlier). NA-A	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 stated it was R6's bath day and they were not able to do anything with him until his bed had been washed. -At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was changed and perianal care was provided. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should have been repositioned every two hours and had not been since he got up in the morning. On 6/8/16, at 1:04 p.m. NA-A stated if R6 was combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not reapproached R6 and he had gone 3 hours and 18 minutes without repositioning/offloading. On 6/9/16, at 8:36 a.m. the director of nursing (DON) confirmed R6 should have been repositioned/offloaded every two hours as directed on his care plan. The undated Prevention of Pressure Ulcers policy, directed staff general pressure ulcer preventive measures included change of position at least every hour for a person in a chair.	F 314		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete laboratory blood tests as ordered by the physician for 1 of 5 residents (R14) reviewed for unnecessary medications. Findings include: R14's annual Minimum Data Set (MDS) dated 5/8/16, indicated R14 had severe cognitive impairment and had diagnoses which included hypertension, anemia, and adult failure to thrive. R14's Physician Order Report dated 5/9/16 - 6/9/16, revealed physician orders dated 3/20/15, for the following: --Basic metabolic panel (BMP) (blood test that measures glucose level, electrolyte and fluid balance, and kidney function. Glucose is a type of sugar the body uses for energy. Electrolytes keep the body's fluids in balance) on the 25th of every 6th month --Complete blood count (CBC) (a panel of tests that evaluates the three types of cells that circulate in the blood. It is often used as a broad screening test to determine an individual's general health status) on the 25th of every 6th month. --Free thyroxine (Free T4) (a test used to help evaluate thyroid function and diagnose thyroid diseases), Thyroid-stimulating hormone (TSH) (blood test used to check for thyroid gland problems) and Iron panel (group of blood tests used to evaluate body iron stores or the iron level in blood serum) annually on March 25th. Review of R14's medical record revealed the most recent laboratory results for CBC, BMP,	F 502	Cornerstone Nursing and Rehab Center strives to ensure that a resident who enters the facility will have laboratory services to meet the needs of the resident's medications R14, care plan was reviewed for resident resisting lab work on 6/26/16 and was updated according to physician and families wishes for resident lab work. Facility policies and documentation systems were reviewed on 6/26/16, and were current. A mandatory in-service for nursing personnel on 6/20/16 and 7/6/16, to address the importance of following care plans and documenting refusals by residents for any type of cares. The Director of Nursing or designee shall complete monthly random audits of labs being completed for 3 months and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 13 Free T4, TSH, and Iron panel were dated 3/25/15. The record lacked further laboratory test results. On 6/9/16, at 8:07 a.m. the director of nursing (DON) confirmed the most recent laboratory results available for R14 were dated 3/25/15. The DON stated it could be difficult to obtain a blood specimen from R14, but she wasn't sure if R14 had refused and the lab work never got followed up on or what had happened. The DON confirmed R14 should have had lab work performed as ordered by the physician. The undated Writing Orders policy directed physicians provide timely, accurate and complete orders. The undated Medication Orders policy indicated treatment orders would specify the specific treatment, frequency and duration of the treatment.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cornerstone Nursing and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

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

Electronically Signed | 06/29/2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 and Angela.Kappenman@state.mn.us	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The facility was inspected as two separate buildings:
The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction and is separated by a 2 hour fire barrier. This addition is fully sprinkled.

The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection is in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 have battery operated smoke detectors installed. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code (2007 edition). The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 43 residents and undetermined amount of staff and visitors Findings include:	K 050	Cornerstone Nursing and Rehab Center strives to ensure required fire drills are conducted at a minimum of quarterly on each shift. Previous fire drills for this calendar year were reviewed and completed quarterly on each shift. The fire drill schedule for the calendar year has been reviewed and is included in the monthly maintenance checklist. The Environmental Services Supervisor shall be responsible for ensuring compliance.	7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 3 On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 record review and staff interview revealed one fire drill was missed in the last 12 months. June of 2015. This deficient condition was verified by the Enviromental Services Director.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 43 residents and an undtermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 record review and staff interview revealed two quarterly sprinkler flow tests were missed. 3rd and 4th quarter of 2015. This deficient practice was verified by the	K 062	Cornerstone Nursing and Rehab Center is a fully sprinkler protected facility and shall ensure the system is continuously maintained in reliable operating condition through inspection and testing. Previous sprinkler water flow tests for this calendar year were reviewed and completed quarterly on each shift. The quarterly water flow test policy and procedures were reviewed. Documentation shall be maintained and reviewed by the Environmental Services Supervisor to ensure compliance.	7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 Environmental Services Director.	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cornerstone Nursing and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us	K 000	EPCC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two separate buildings: The Cornerstone Nursing and Rehab Center was built in 1968, is a 1-story building, with a partial basement and was determined to be of a Type II (222) construction. A 1 story building without basement addition was added in 2015 and was determined to be of Type V(111) construction. In 2016 an addition was added to the end of the west wing and was determined to be of a Type V (111) construction and is separated by a 2 hour fire barrier. This addition is fully sprinkled. The facility is completely sprinkler protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with additional automatic smoke detection is in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 have battery operated smoke detectors installed. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code (2007 edition). The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD 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 101-2000 edition, Sections 18.3.7.1, 18.3.7.3. This deficient practice could allow the products of combustion to spread throughout the smoke compartment in the event of a fire which could affect 9 of the 43 residents,and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 observations and staff interview revealed a penetration above the corridor doors in the smoke barrier in the 300 wing near resident room 303.	K 025	Cornerstone Nursing and Rehab Center strives to ensure all smoke barrier walls are constructed to provide appropriate fire resistance rating. On June 8th, 2016, the noted penetration was properly sealed to prevent the potential spread of any products of combustion throughout the smoke compartment. Additional ceiling tiles along both sides of smoke barrier doors were inspected for appropriate barrier. Annual smoke barrier inspections have been added to the Preventative Maintenance Log. The Environmental Services Supervisor shall be responsible for ensuring compliance.	7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 3 This deficient condition was verified by the Environmental Services Director.	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 43 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 record review and staff interview revealed one fire drill was missed in the last 12 months. June of 2015. This deficient condition was verified by the Environmental Services Director.	K 050	Cornerstone Nursing and Rehab Center strives to ensure required fire drills are conducted at a minimum of quarterly on each shift. Previous fire drills for this calendar year were reviewed and completed quarterly on each shift. The fire drill schedule for the calendar year has been reviewed and is included in the monthly maintenance checklist. The Environmental Services Supervisor shall be responsible for ensuring compliance.	7/1/16
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=F	Continued From page 4 Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 43 residents, and an undermined amount of staff and visitors. Findings include: On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 record review and staff interview revealed two quarterly sprinkler flow tests were missed. 3rd and 4th quarter of 2015. This deficient practice was verified by the Environmental Services Director.	K 062	Cornerstone Nursing and Rehab Center is a fully sprinkler protected facility and shall ensure the system is continuously maintained in reliable operating condition through inspection and testing. Previous sprinkler water flow tests for this calendar year were reviewed and completed quarterly on each shift. The quarterly water flow test policy and procedures were reviewed. Documentation shall be maintained and reviewed by the Environmental Services Supervisor to ensure compliance.	
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft sq. (20.4 L/m sq.). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft sq. (5.9-m sq.) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall	K 075		7/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING **02 - 2015 ADDITION** B. WING _____	**06/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 075	Continued From page 5 be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.5.5. This deficient practice could affect the safety of 9 of the 43 residents and an undtermined amount of staff and visitors if smoke or fire from one of these carts rendered the corridor untenable. Findings include: On the facility tour between 9:15 am to 1:00 pm on 06/07/2016 observations and staff interview revealed a trash and soiled linen cart exceeding 32 gallons was left unattended in the 300 wing corridor. This deficient practice was verified by the Environmental Services Director.	K 075	Cornerstone Nursing and Rehab Center strives to ensure a safe and sanitary environment by ensuring soiled linen and trash collection receptacles are stored in the designated locations. Nursing personnel were educated on June 20, 2016, regarding the designated locations of the carts containing soiled linen and trash. The nursing assistant orientation checklist was reviewed to ensure appropriate training is given upon orientation. The Environmental Services Supervisor or designee shall complete weekly audits for 4 weeks to ensure compliance.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 22, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5307026 and H5307013

Dear Ms. Swanson:

The above facility was surveyed on June 6, 2016 through June 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5307013. that was found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 June 6th, 7th, 8th, and 9th, 2016, 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. A complaint investigation was conducted for complaint number H5307013 and found to be unsubstantiated. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided as directed by the care plan for 1 of 3 residents (R68) who required assistance with oral hygiene and was not provided the assistance. The facility also failed to ensure repositioning and incontinence care was provided as directed by the care plan for 1 of 3 residents (R6) identified at risk for pressure ulcers and was incontinent or bowel/bladder and dependent on staff for these services. Findings include: R68 was not provided assistance with oral hygiene as directed by the care plan. R68's Care Plan dated 4/2/16, indicated R68 required assist of one staff to complete oral hygiene.	2 565	Corrected	7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 On 6/8/16, at 7:30 am. nursing assistant (NA)-D was observed to provide R68 morning cares. During the observation, NA-D was observed to place R68's upper denture and lower partial into R68's mouth without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-D assisted R68 into a wheelchair and wheeled R68 out of the room. At no time did NA-D offer R68 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/8/16, at 8:55 a.m. NA-D verified oral hygiene was not completed prior to inserting R68's dentures. NA-D stated she usually utilized a mint flavored mouth swab to cleanse R68's mouth, however, she had forgot to. On 6/9/16, at 9:05 a.m. the director of nursing (DON) verified R68's care plan and stated oral hygiene should have been provided, as directed. The undated facility Brushing Teeth policy, indicated a resident should be assisted with brushing his or her teeth based on his or her individual needs. R6 did not receive repositioning assistance or bowel incontinence care as directed by the care plan for three hours and 18 minutes on 6/8/16. R6's Care Plan dated 3/22/16, directed one-two staff to turn and reposition and check and change incontinent brief every two hours in an attempt to preserve skin integrity.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 On 6/8/16, at 7:52 a.m. NE-E was observed to enter R6's room and proceed to provide morning cares. At 8:07 a.m. following the completion of cares, NE-E and NA-A assisted R6 into the wheelchair and wheeled R6 near the dining room. R6 was continuously observed following the provision of morning cares. -At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. -At 9:28 a.m. NA-B wheeled R6 to the hallway where he remained until 9:45 a.m. -At 9:45 a.m. NA-A wheeled R6 to room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m. -At 11:20 a.m. NA-A stated they had not been able to check, change or reposition R6 since he got up in the morning. NA-A also stated it was R6's bath day and they were not able to do anything until his bed had been washed. -At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was observed to be dry of urine, however, R6 had been incontinent of stool. NA-A changed R6's incontinent brief and provided perianal care. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should have been checked, changed and repositioned every two hours and had not been since he was assisted up in the morning. (3 hours and 18 minutes earlier) On 6/8/16, at 1:04 p.m. NA-A stated if R6 was combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 reapproached R6 and he had gone 3 hours and 18 minutes without repositioning, offloading or check/change for incontinence. On 6/9/16, at 8:36 a.m. the DON confirmed R6 should have been repositioned/offloaded and incontinent brief checked/changed every two hours as directed on his care plan. The undated Using the Care Plan policy indicated the care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had responsibility for providing care or services to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the implementation of the care plan related to oral hygiene and incontinence care. The DON or designee, could provide training for all nursing staff related to following the care plan. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	2 900		7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 3 residents (R6) identified at risk for the development of a pressure ulcer and required staff assistance to reposition. Finding include: R6's annual Minimum Data Set (MDS) dated 3/20/16, indicated R6 was severely cognitively impaired and had diagnoses which included paranoid schizophrenia, contracture (fixed high resistance to passive stretch of a muscle), glaucoma and chronic obstructive pulmonary disease. The MDS indicated R6 required extensive assistance of two staff for bed mobility, was totally dependent upon two staff for transfers and toilet use and was totally dependent upon one staff member for personal hygiene. The MDS further indicated R6 was at risk for the development of a pressure ulcer and required a turning and repositioning program.	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 R6's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 3/22/16, indicated R6 was at risk for the development of pressure ulcers. The CAA indicated nursing would continue to check/change and toilet R6 as requested, at least every two hours, in conjunction with an offloading schedule in an attempt to maintain skin integrity and decrease incontinent episodes. R6's Skin Risk Assessment with Braden Scale dated 3/18/16, indicated R6 was at risk for the development of a pressure ulcer and required pressure reducing devices for chair and bed and required a turning and repositioning program. R6's Tissue Tolerance Test dated 3/18/16, indicated R6 required staff assist with toileting needs every two hours and R6 would be repositioned, turned or offloaded in conjunction with toileting in attempt to maintain skin integrity. R6's Care Plan dated 3/22/16, indicated staff must anticipate all R6's cares/needs. The Care Plan also indicated R6 had contractures in all extremities including deformed and contracted hands, especially the left and was unable to stand or ambulate safely. The Care Plan further indicated R6 required assistance of 1-2 staff to turn, reposition and offload and directed this be done every two hours and as needed. On 6/8/16, at 7:52 a.m. nursing assistant (NA)-E was observed to enter R6's room provide morning cares. R6's skin was observed without redness to bony prominences. R6 was observed to strike out and kick during cares. NA-E maintained a calm approach, explained what she was doing and redirected R6 when this occurred. R6 was dressed and a mechanical lift sling was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8	2 900		

placed under him. NA-A entered the room and R6 was transferred into a wheelchair at 8:07 a.m. R6 was shaved and oral cares were offered. R6 was then wheeled out of the room and placed in the hallway outside the dining room. R6 was continuously observed seated in his wheelchair in the hallway.
-At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. R6 was continuously observed seated in the dining room.
-At 9:28 a.m. NA-B wheeled R6 to the hallway and he remained seated in the hallway until 9:45 a.m.
-At 9:45 a.m. NA-A wheeled R6 to room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m.
-At 11:20 a.m. NA-A stated they had not been able to reposition R6 since he got up in the morning (3 hours and 18 minutes earlier). NA-A stated it was R6's bath day and they were not able to do anything with him until his bed had been washed.
-At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was changed and perianal care was provided. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should have been repositioned every two hours and had not been since he got up in the morning.

On 6/8/16, at 1:04 p.m. NA-A stated if R6 was combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not reapproached R6 and he had gone 3 hours and 18 minutes without repositioning/offloading.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 On 6/9/16, at 8:36 a.m. the director of nursing (DON) confirmed R6 should have been repositioned/offloaded every two hours as directed on his care plan. The undated Prevention of Pressure Ulcers policy, directed staff general pressure ulcer preventive measures included change of position at least every hour for a person in a chair. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to pressure ulcer prevention. The DON or designee, could provide training for all nursing staff related to pressure ulcers and the importance of repositioning. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by:	2 920		7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 10 Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided for 1 of 3 residents (R68) who required assistance with oral hygiene. In addition, the facility failed to ensure bowel incontinence care was provided for 1 of 3 resident (R6) who was dependent on staff for assistance. Findings include: R68 was not provided oral hygiene on the morning of 6/8/16, as directed by the care plan. R68's initial Minimum Data Set (MDS) dated 4 /9/16, indicated R68 had diagnoses of dementia, chronic obstructive disease (COPD), and diabetes. The MDS also indicated R68 had impaired cognition and required extensive assistance for mobility, dressing and personal hygiene. The MDS further indicated R68 had no dental concerns. R68's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 4/13/16, indicated R68 required extensive assistance with dressing, grooming, and physical assistance with bathing due to impaired balance with transfers and ambulation, had a recent hospitalization with increased confusion and weakness. R68's Care Plan dated 4/2/16, indicated R68 required assist of one staff to complete oral hygiene. On 6/8/16, at 7:30 am. nursing assistant (NA)-D was observed to provide R68 morning cares. During the observation, NA-D was observed to place R68's upper denture and lower partial into R68's mouth without providing or offering the	2 920	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 11 opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-D assisted R68 into a wheelchair and wheeled R68 out of the room. At no time did NA-D offer R68 the opportunity to brush her remaining lower teeth or rinse her mouth prior to inserting the clean dentures. On 6/8/16, at 8:55 a.m. NA-D verified oral hygiene was not completed prior to inserting R68's dentures. NA-D stated she usually utilized a mint flavored mouth swab to cleanse R68's mouth, however, she forgot to. On 6/9/16, at 9:05 a.m. the director of nursing (DON) verified R68's care plan was correct and stated oral hygiene should have been provided, as directed. The undated, facility Mouth Care policy indicated the purpose of mouth care was to keep the resident's lips and oral tissue moist, to cleanse and freshen the resident's mouth, and prevent infections of the mouth. The undated facility Brushing Teeth policy indicated a resident should be assisted with brushing his or her teeth based on his or her individual needs. R6 did not receive bowel incontinence care for three hours and 18 minutes on 6/8/16. R6's annual MDS dated 3/20/16, indicated R6 had severely impaired cognition and diagnoses which included paranoid schizophrenia, contracture (fixed high resistance to passive	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 12 stretch of a muscle), glaucoma and chronic obstructive pulmonary disease. The MDS indicated R6 required extensive assistance of two staff for bed mobility, was totally dependent upon two staff for transfer and toilet use and was totally dependent upon one staff member for personal hygiene. The MDS further indicated R6 was always incontinent of bowel and bladder and did not participate in a toileting program to manage continence. R6's Urinary Incontinence and Indwelling Catheter CAA dated 3/22/16, indicated R6 was incontinent of bowel and bladder and required assistance with toileting and bed mobility. The CAA indicated R6 wore incontinence products at all times and was able to alert staff to the urge of a bowel movement once during the MDS assessment period however most times he was incontinent. The CAA indicated R6's cognition was severely impaired and he was not a candidate for bowel/bladder training. The CAA further indicated nursing would continue to check/change and toilet R6 as requested, at least every 2 hours, in conjunction with an offloading schedule in an attempt to maintain skin integrity and decrease incontinent episodes. R6's Care Plan dated 3/22/16, indicated staff must anticipate all R6's cares/needs. The plan indicated R6 was incontinent of bowel and bladder and would rarely alert staff of needs. The plan futher indicated R6 was not a candidate for toilet training related to poor cognition and directed staff to check and change R6 at least every two hours. On 6/8/16, at 7:52 a.m. NA-E was observed to assist R6 with morning cares. -At 8:07 a.m. following the completion of morning	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 13	2 920		

cares, NA-A and NA-E transferred R6 into the wheelchair. R6 was then shaved and oral cares were offered. R6 was wheeled out of the room and placed in the hallway outside the dining room. Following the observation, R6 was continuously observed seated in his wheelchair.
-At 9:15 a.m. NA-B wheeled R6 into the dining room and assisted him to eat breakfast. R6 was continuously observed seated in the dining room.
-At 9:28 a.m. NA-B wheeled R6 to the hallway where he remained seated in the hallway until 9:45 a.m.
-At 9:45 a.m. NA-A wheeled R6 to his room and attempted to check him. R6 struck NA-A in the abdomen and was combative. NA-A returned R6 to the hallway. R6 remained seated in the hallway until 11:20 a.m.
-At 11:20 a.m. NA-A stated they had not been able to check, change or reposition R6 since he got up in the morning. NA-A stated it was R6's bath day and they were not able to do anything with him until his bed had been washed.
-At 11:25 a.m. NA-A and NA-C returned R6 to his room and transferred him to the bed with the use of the ceiling lift. R6's incontinent brief was observed to be dry of urine, however, R6 had been incontinent of stool. NA-A changed R6's incontinent brief and provided perianal care. R6's buttocks and bony prominences did not appear red and his skin was intact. NA-A confirmed R6 should be checked, changed and repositioned every two hours and he had not been since he got up in the morning. (3 hours and 18 minutes earlier)

On 6/8/16, at 1:04 p.m. NA-A stated if R6 was combative with care she would leave and reapproach later. NA-A stated she should have checked back and reapproached R6 after 10-15 minutes. NA-A confirmed she had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 14 reapproached R6 and he had gone 3 hours and 18 minutes without incontinence care. On 6/9/16, at 8:36 a.m. the DON confirmed R6 should have been checked and incontinent product changed every two hours as directed on his care plan. No policy regarding bowel incontinence was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the implementation of the care plan related to the provision of oral hygiene and incontinence cares. The DON or designee, could provide training for all nursing staff related to providing the services. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		