DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	UW9B
Faci	ility ID: 00074

MEDICARE/MEDICAID PROVID (L1)	NO.	3. NAME AND AI (L3) CORNERST (L4) 416 SEVEN' (L5) BAGLEY, M 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	TONE NSG & TH STREET I	REHAB C	(L6) 56621 <u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After	2. Recertification 4. CHOW 6. Complaint 9. Other
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	43 (L18) 43 (L17)	Compliance1. A B. Not in Comp	equirements e Based On:	ram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of So 7. Medical Di	ervices Limit rector
14. LTC CERTIFIED BED BREAKDO	OWN		11		15. FACILITY MEETS		
18 SNF 18/19 SNF 43	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM See Attached Remarks	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Teresa Ament, Unit	Supervisor	0	08/08/2016	(L19)	Mark Meath	, Enforcement Spec	09/16/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBIE _X 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stmt	*
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 03/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to	NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	er Status Change
(L27)	B. Rescind St	uspension Date:	(L45)			001101110	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 07/19/2016	OF APPROVAI	L DATE			
	(L32)	01/13/2010		(L33)	DETERMINATION APP	ROVAL	



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 Weath

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



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 Weath

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

POST-CERTIFICATION REVISIT REPORT

				_	
	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	ISIT
245307 _{Y1}	B. Wing		Y2	7/25/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORNERSTONE NSG & REHA	AB CENTER	416 SEVENTH STREET NORTHEAST			
		BAGLEY, MN 56621			
This report is completed by a qu	ualified State surveyor for the Medicare	Medicaid and/or Clinical Laboratory Improvement	ent	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).

ITE 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		
REVIEWE STATE A		REVIEWED BY (INITIALS) LB/mm	DATE 08/08/2016	SIGNATURE OF SURVEYOR 28035		DAT 07,	E /25/2016
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE		DAT	E
FOLLOW 6/9/2016		Y COMPLETED ON		R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567		IE ELOU IT (0	YES NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		Di	ATE OF REVI	ISIT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING				
245307 _{Y1}	B. Wing	Y2	<u>,</u> 7/	/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORNERSTONE NSG & REHA	AB 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).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix		Correction	ID Prefix	Correc	tion ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Comple	eted Reg. #	Completed
LSC	K0050	07/01/2016	LSC K0062	07/01/2	016 LSC	
ID Prefix		Correction	ID Prefix	Correc	tion ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	eted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correc	tion ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	eted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correc	tion ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	eted Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correc	tion ID Prefix	Correction
Reg. #		Completed	Reg. #	Comple	eted Reg. #	Completed
LSC			LSC		LSC	
REVIEWI STATE A		REVIEWED BY (INITIALS)TL/mm	DATE 08/08/2016	SIGNATURE OF SURVEY	OR 36536	DATE 07/18/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOW 6/7/2016		Y COMPLETED ON		R ANY UNCORRECTED DE CTED DEFICIENCIES (CMS		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REV	VISIT
	A. Building 02 - 2015 ADDITION B. Wing	Y	1 2	7/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORNERSTONE NSG & REHA	AB 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).

ITE 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. #	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			
REVIEWI STATE A		REVIEWED BY (INITIALS)TTL/mm	DATE 08/08/2016	SIGNATURE OF	SURVEYOR	36536		DATE 07/1	.8/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW 6/7/2016		Y COMPLETED ON		R ANY UNCORREC				YE	s 🗆 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UW9B Facility ID: 00974

MEDICARE/MEDICAID PROVIDER NO. (L1) 245307 2.STATE VENDOR OR MEDICAID NO.	3. NAME AND A	DDDEGG OF ELG	TIL TOTAL		4. TYPE OF ACTION: 2 (L8)
	(L3) CORNERS	3. NAME AND ADDRESS OF FACILITY (L3) CORNERSTONE NSG & REHAB CENTER (L4) 416 SEVENTH STREET NORTHEAST			1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 458430000	(L5) BAGLEY, N	MN		(L6) 56621	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2008	7. PROVIDER/SU	UPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 06/09/2016 (L34 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 43 (L18)	Complianc1. A X B. Not in Co		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SI 43	IF ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L38)	(L42)	(L43)			
(E37) (E30) (E3.					
16. STATE SURVEY AGENCY REMARKS (IF APPI See Attached Remarks	ICABLE SHOW LTC CA	ANCELLATION :	DATE):		
16. STATE SURVEY AGENCY REMARKS (IF APPI	ICABLE SHOW LTC CA		DATE):	18. STATE SURVEY AGENCY	APPROVAL Date:
16. STATE SURVEY AGENCY REMARKS (IF APPI See Attached Remarks	Date :			18. STATE SURVEY AGENCY	
16. STATE SURVEY AGENCY REMARKS (IF APPI See Attached Remarks 17. SURVEYOR SIGNATURE YVONNE Switajewski, HFE NEII	Date :	07/07/2016	(L19)		Enforcement Specialist 07/15/2016 (L2
16. STATE SURVEY AGENCY REMARKS (IF APPL See Attached Remarks 17. SURVEYOR SIGNATURE YVONNE Switajewski, HFE NEII PART II - TO E 19. DETERMINATION OF ELIGIBILITY	Date : EE COMPLETED 20. COM	07/07/2016	(L19)	OFFICE OR SINGLE S 21. 1. Statement of Fina 2. Ownership/Contro	Enforcement Specialist 07/15/2016 (L2 STATE AGENCY Incial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
16. STATE SURVEY AGENCY REMARKS (IF APPI See Attached Remarks 17. SURVEYOR SIGNATURE YVONNE Switajewski, HFE NEII PART II - TO E	Date : EE COMPLETED 20. COM	07/07/2016 BY HCFA RE	(L19)	Monk Meath, OFFICE OR SINGLE S 21. 1. Statement of Fina	Enforcement Specialist 07/15/2016 (L2 STATE AGENCY Incial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UW9B Facility ID: 00974

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 Certification Revisit (PCR) to follow.



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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.

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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

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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

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

Sincerely,



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

PRINTED: 07/07/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY PLETED
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	Department's accept enrolled in ePOC, year the bottom of the	of compliance upon the chance. Because you are cour signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance.				
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with				
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	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on observat review, the facility fa was provided as dir 3 residents (R68) w oral hygiene and wa assistance. The fac repositioning and in as directed by the o	cility also failed to ensure continence care was provided care plan for 1 of 3 residents		Cornerstone Nursing and Rehab strives to provide and arrange for provided by qualified persons in accordance with each resident splan of care. Education and revisi have been made to assure that this being accomplished. R6, care plan was reviewed for	services written ons is is	
LABORATOR'	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	((X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed**

06/28/2016

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.

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F 282	brushing his or her individual needs. R6 did not receive is bowel incontinence plan for three hours. R6's Care Plan data staff to turn and repincontinent brief ever preserve skin integ. On 6/8/16, at 7:52 a enter R6's room an cares. At 8:07 a.m. cares, NE-E and Nawheelchair and wheelchair and assisted and assisted and several and	repositioning assistance or care as directed by the care and 18 minutes on 6/8/16. Red 3/22/16, directed one-two position and check and change ery two hours in an attempt to rity. A.m. NE-E was observed to diproceed to provide morning following the completion of A-A assisted R6 into the eeled R6 near the dining room. By observed following the gicares. Wheeled R6 into the dining him to eat breakfast. Wheeled R6 to the hallway		282	DEFICIENCY)		
	to the hallway. R6 hallway until 11:20 a-At 11:20 a.m. NA-A able to check, changot up in the mornin R6's bath day and tanything until his be-At 11:25 a.m. NA-A room and transferre of the ceiling lift. R	remained seated in the a.m. A stated they had not been ge or reposition R6 since he ng. NA-A also stated it was hey were not able to do ed had been washed. A and NA-C returned R6 to his ed him to the bed with the use 6's incontinent brief was					
	room and transferre of the ceiling lift. R observed to be dry	ed him to the bed with the use					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 312	which included para contracture (fixed h stretch of a muscle) obstructive pulmona indicated R6 require staff for bed mobility two staff for transfedependent upon on hygiene. The MDS always incontinent on participate in a strength of the participate in an attent of the participate and strength of the participate all findicated R6 was in bladder and would a plan futher indicated toilet training related to the participate and the participate and the plan futher indicated toilet training related to the participate and the plan futher indicated toilet training related to the participate and the plan futher indicated toilet training related to the participate and the plan futher indicated to the participate and the plan futher indicated toilet training related to the participate and the plan futher indicated to the participate and the plan futher indicated to the participate and the plan futher indicated toilet training related to the participate and the plan futher indicated to the participate and the par	anoid schizophrenia, igh resistance to passive and chronic ary disease. The MDS and extensive assistance of two and toilet use and was totally estaff member for personal further indicated R6 was and bladder and did toileting program to manage and bladder and required and bladder training. The was AA indicated R6's cognition and he was not a wolld bladder training. The CAA resing would continue to so toilet R6 as requested, at least an indication with an offloading anot to maintain skin integrity	F 3	12		

AND DI AN OF CODDECTION IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED				
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 312	On 6/8/16, at 7:52 a assist R6 with morrat 8:07 a.m. follow cares, NA-A and NA wheelchair. R6 was were offered. R6 wand placed in the haroom. Following the continuously observat 9:15 a.m. NA-B room and assisted continuously observat 9:28 a.m. NA-B where he remained 9:45 a.mAt 9:45 a.m. NA-A attempted to check abdomen and was to the hallway. R6 hallway until 11:20 a-At 11:20 a.m. NA-A able to check, changot up in the mornin bath day and they with him until his beat 11:25 a.m. NA-A room and transferred from the ceiling lift. Robserved to be dry been incontinent of incontinent brief and buttocks and bony pred and his skin was should be checked, every two hours and got up in the morning earlier)	a.m. NA-E was observed to hing cares. ing the completion of morning A-E transferred R6 into the other shaved and oral cares has wheeled out of the room allway outside the dining e observation, R6 was wed seated in his wheelchair. Wheeled R6 into the dining him to eat breakfast. R6 was wed seated in the dining room. Wheeled R6 to the hallway seated in the hallway until a wheeled R6 to his room and him. R6 struck NA-A in the combative. NA-A returned R6 remained seated in the	F3	812		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	` /	E SURVEY PLETED
		245307	B. WING		06/	09/2016
	PROVIDER OR SUPPLIER	AB CENTER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 16 SEVENTH STREET NORTHEAST BAGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	reapproach later. No checked back and minutes. NA-A con reapproached R6 at 18 minutes without. On 6/9/16, at 8:36 as should have been controlled by the product changed exhibits care plan.	e she would leave and IA-A stated she should have reapproached R6 after 10-15 firmed she had not nd he had gone 3 hours and	F 312			
F 314 SS=D	resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recessives to promote prevent new sores. This REQUIREMENT by: Based on observations.	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and	F 314	Cornerstone Nursing and Rehab C strives to ensure that a resident wh		7/11/16
	repositioning was p (R6) identified at ris	rovided for 1 of 3 residents k for the development of a required staff assistance to		enters the facility without pressure does not develop pressure sores u the individual's condition demonstrathat they were unavoidable. A residualing pressure sores must receive	sores nless ates dent	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245307	B. WING			06/0	09/2016
	PROVIDER OR SUPPLIER	AB CENTER		41	TREET ADDRESS, CITY, STATE, ZIP CODE 16 SEVENTH STREET NORTHEAST AGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	3/20/16, indicated I impaired and had of paranoid schizophr resistance to passing glaucoma and chrodisease. The MDS extensive assistant was totally dependent and toilet use and cone staff member of MDS further indicated development of a paturning and reposition. R6's Urinary Incont Catheter Care Area 3/22/16, indicated I development of presindicated nursing wand toilet R6 as reconstruction an attempt to madecrease incontine. R6's Skin Risk Assing development of a paressure reducing a required a turning a R6's Tissue Tolerar indicated R6 required needs every two herepositioned, turned.	um Data Set (MDS) dated R6 was severely cognitively liagnoses which included enia, contracture (fixed high we stretch of a muscle), inic obstructive pulmonary indicated R6 required be of two staff for bed mobility, ent upon two staff for transfers was totally dependent upon or personal hygiene. The sted R6 was at risk for the pressure ulcer and required a coning program. Intended and Indwelling a Assessment (CAA) dated R6 was at risk for the essure ulcers. The CAA could continue to check/change quested, at least every two on with an offloading schedule sintain skin integrity and	F 3	14	necessary treatment and services the promote healing, prevent infection prevent new sores from developing R6, care plan was reviewed for repositioning schedules on 6/25/16 were current. Facility policies and documentation systems were revie 6/25/16, with updates made. Nursito attend a mandatory in-service or 6/20/16 and 7/6/16, which address importance of following care plans review updated policies. The Director of Nursing or designed complete weekly random audits of repositioning of residents for 3 week quarterly thereafter for 6 months or compliance has been reached. Residness audits will be reported at the QA meetings.	and and wed on ng staff ned the and e shall ks and until sults of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245307	B. WING		06/	09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 SEVENTH STREET NORTHEAST BAGLEY, MN 56621		33,23.3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 314	R6's Care Plan dat must anticipate all Plan also indicated extremities includir hands, especially tor ambulate safely indicated R6 requir turn, reposition and done every two hor On 6/8/16, at 7:52 was observed to en morning cares. R6 redness to bony prostrike out and kin maintained a calm was doing and redirect R6 was dressed and placed under him. R6 was transferred R6 was shaved and was then wheeled the hallway outside continuously obserthe hallway. At 9:15 a.m. NA-Band he remained sa.m. At 9:45 a.m. NA-Band he remained sa.m. At 19:45 a.m. NA-Band he remained sa.m.	red 3/22/16, indicated staff R6's cares/needs. The Care R6 had contractures in all ng deformed and contracted he left and was unable to stand. The Care Plan further red assistance of 1-2 staff to doffload and directed this be turn and as needed. a.m. nursing assistant (NA)-Enter R6's room provide is skin was observed without ominences. R6 was observed ock during cares. NA-E approach, explained what she irected R6 when this occurred. Indicate a mechanical lift sling was NA-A entered the room and into a wheelchair at 8:07 a.m. do oral cares were offered. R6 out of the room and placed in the dining room. R6 was ved seated in his wheelchair in wheeled R6 into the dining room. In wheeled R6 to the hallway eated in the hallway until 9:45 a wheeled R6 to room and the combative. NA-A returned R6 remained seated in the	F 314			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY PLETED
		245307	B. WING _		06/09/2016	
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	able to do anything been washedAt 11:25 a.m. NA-A room and transferred of the ceiling lift. Rechanged and periar buttocks and bony pred and his skin washould have been reand had not been such a combative with care reapproach later. Notecked back and minutes. NA-A con reapproached R6 a 18 minutes without On 6/9/16, at 8:36 a (DON) confirmed R	ath day and they were not with him until his bed had A and NA-C returned R6 to his ed him to the bed with the use 6's incontinent brief was hal care was provided. R6's prominences did not appear in sintact. NA-A confirmed R6 epositioned every two hours ince he got up in the morning. D.m. NA-A stated if R6 was eshe would leave and IA-A stated she should have reapproached R6 after 10-15 firmed she had not not he had gone 3 hours and repositioning/offloading. A.m. the director of nursing 6 should have been led every two hours as	F 3	14		
F 502 SS=D	policy, directed staff preventive measure at least every hour to 483.75(j)(1) ADMIN The facility must pro- services to meet the	ntion of Pressure Ulcers f general pressure ulcer es included change of position for a person in a chair. IISTRATION ovide or obtain laboratory e needs of its residents. The e for the quality and timeliness	F 50	02		7/11/16

	OF CODDECTION IDENTIFICATION NUMBER.			MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		245307	B. WING			06/0	09/2016	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				4	TREET ADDRESS, CITY, STATE, ZIP CODE 16 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 502	This REQUIREMENT by: Based on interview facility failed to comordered by the physical (R14) reviewed for Findings include: R14's annual Minim 5/8/16, indicated Raimpairment and had hypertension, anem R14's Physician Ore 6/9/16, revealed phore the following:Basic metabolic polar measures glucosed balance, and kidnessugar the body set fluids in 6th monthComplete blood control that evaluates the truliate in the blood screening test to degeneral health statumonthFree thyroxine (Frevaluate thyroid fundiseases), Thyroid (blood test used to problems) and Iron used to evaluate both in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum) and Review of R14's measures glucosed in blood serum and R14's R14's measures glucosed in blood serum and R14's R	ge 12 IT is not met as evidenced and document review, the plete laboratory blood tests as sician for 1 of 5 residents unnecessary medications. It may be a series of the series of th	F 5	02	Cornerstone Nursing and Rehab C strives to ensure that a resident whenters the facility will have laborate services to meet the needs of the resident's medications R14, care plan was reviewed for reresisting lab work on 6/26/16 and wupdated according to physician and families wishes for resident lab wor Facility policies and documentation systems were reviewed on 6/26/16 were current. A mandatory in-servinursing personnel on 6/20/16 and 7 to address the importance of follow care plans and documenting refusaresidents for any type of cares. The Director of Nursing or designed complete monthly random audits of being completed for 3 months and quarterly thereafter for 6 months or compliance has been reached. Resthese audits will be reported at the QA meetings.	sident vas dirk. , and ice for 7/6/16, ving als by e shall f labs		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED 06/09/2016 CITY, STATE, ZIP CODE REET NORTHEAST 6621 DER'S PLAN OF CORRECTION (X5) DERRECTIVE ACTION SHOULD BE COMPLETION			
		245307	B. WING			06/0	09/2016		
	PROVIDER OR SUPPLIER	AB CENTER		416	EET ADDRESS, CITY, STATE, ZIP CODE SEVENTH STREET NORTHEAST GLEY, MN 56621				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION		
F 502	Free T4, TSH, and 3/25/15. The recorresults. On 6/9/16, at 8:07 a (DON) confirmed the results available for DON stated it could specimen from R12 had refused and thoughout on or what had be confirmed R14 shoperformed as order. The undated Writin physicians provide orders. The undate indicated treatment.	ge 13 Iron panel were dated d lacked further laboratory test a.m. the director of nursing ne most recent laboratory R14 were dated 3/25/15. The lab difficult to obtain a blood lab, but she wasn't sure if R14 e lab work never got followed nappened. The DON uld have had lab work ed by the physician. If a Corders policy directed timely, accurate and complete d Medication Orders policy orders would specify the frequency and duration of the	F 5	02					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION 11 - MAIN BUILDING		E SURVEY IPLETED
		245307	B, WING		06/	07/2016
	PROVIDER OR SUPPLIER	AB CENTER	ST 41 B/			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS F COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.				
	Minnesota Departr time of this survey Rehab Center was compliance with th in Medicare/Medic 483.70(a), Life Sat edition of National	e Survey was conducted by the ment of Public Safety. At the , Cornerstone Nursing and so found not in substantial ne requirements for participation aid at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), and Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	OR THE FIRE SAFETY		EPO	ر	
	Health Care Fire II State Fire Marsha 445 Minnesota Str St. Paul, MN 5510	l Division reet, Suite 145		B		
	Or by e-mail to:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Facility ID: 00974

PRINTED: 06/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION ING 01 - Main Building	(X3) DATE SURVEY COMPLETED		
		245307	B. WING		06	/07/2016	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 000	Continued From pa and Angela.Kappenma		K	000			
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	1. A description of to correct the defic	what has been, or will be, done tiency.	i				
	2. The actual, or p	roposed, completion date.					
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency					
	buildings: The Cornerstone I built in 1968, is a basement and wa (222) construction basement addition determined to be	Nursing and Rehab Center was 1-story building, with a partial s determined to be of a Type II. A 1 story building without a was added in 2015 and was of Type V(111) construction. In was added to the end of the					
	west wing and wa (111) construction	s determined to be of a Type V and is separated by a 2 hour ddition is fully sprinkled.			,		
	an automatic spring accordance with National Installation of Spring The facility has a smoke detection with National Installation is in all accordance with National Installation in the Installation is in all accordance with National Installation in the Installation	pletely sprinkler protected with nkler system installed in NFPA 13 Standard for the inkler Systems 1999 edition. Fire alarm system with corridor with additional automatic smoke common use spaces installed in NFPA 72 "The National Fire 9 edition. All sleeping rooms					

Facility ID: 00974

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION IG 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		245307	B. WING_		06/	07/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	Additional automat all rooms required Code (2007 edition for automatic fire of The facility has a co	age 2 Ited smoke detectors installed, ited fire detection is provided in by the Minnesota State Fire In). The fire alarm is monitored department notification. Iterapacity of 43 beds and had a set time of the survey.	K 06	00			
K 050 SS=F	NOT MET as evide NFPA 101 LIFE SA Fire drills include to signal and simulate conditions. Fire dritimes under varying on each shift. The and is aware that croutine. Responsite conducting drills is persons who are conducting drills are conducting drills are conducting drills are conducting drills are conducting drills. This STANDARD Based on docume interview, it was do to conduct fire drill safety Code 101(12-month period affect how staff relimproper reaction).	he transmission of a fire alarm ion of emergency fire ills are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used	ΚO	Cornerstone Nursing and R strives to ensure required fir conducted at a minimum of each shift. Previous fire drill calendar year were reviewed completed quarterly on each fire drill schedule for the cale has been reviewed and is in monthly maintenance check Environmental Services Supbe responsible for ensuring	e drills are quarterly on ls for this d and n shift. The endar year cluded in the elist. The pervisor shall	7/1/16	

NO DI ANI OF CORRECTION OF THE PROPERTY OF THE		` ′			(X3) DATE SURVEY COMPLETED		
		245307	B. WING	-	REET ADDRESS, CITY, STATE, ZIP CODE	06/0	7/2016
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER			Sav				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 050	on 06/07/2016 red	r between 9:15 am to 1:00 pm cord review and staff interview drill was missed in the last 12	K	050			
K 062 SS=F	Enviromental Ser NFPA 101 LIFE S Required automa continuously mair condition and are periodically. 19 9.7.5 This STANDARD Based on docum with staff, the faci and maintain the accordance with Section 19.7.6, are of Sprinkler System for the Inspection Water Based Fire deficient practice sprinkler system fully operational in negatively affect aundtermined amount of the facility tout on the facility tout.	tic sprinkler systems are ntained in reliable operating inspected and tested .7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: rentation review and interview lity has failed to properly inspect automatic sprinkler system in NFPA 101 Life Safety Code (00), and 4.6.12, NFPA 13 Installation ems (99), and NFPA 25 Standard, Testing and Maintenance of a Protection Systems, (98). This does not ensure that the fire is functioning properly and is in the event of a fire and could all 43 residents and an ount of staff and visitors.	K	0062	Cornerstone Nursing and Rehab Centers a fully sprinkler protected facility and shall ensure the system is continuously maintained in reliable operating conditions through inspection and testing. Previous sprinkler water flow tests for this calend 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.	er , on us dar	7/1/16

		LOCALTICIO ATIONI MILITARED		PLE CONSTRUCTION IG 01 - Main Building	COI	COMPLETED		
		245307	B. WING _		06	/07/2016		
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 062	K 062 Continued From page 4 Environmental Services Director.		K 06	32				

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - 2015 ADDITION B. WING 245307 06/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 416 SEVENTH STREET NORTHEAST **CORNERSTONE NSG & REHAB CENTER BAGLEY, MN 56621** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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. EPCC 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

06/29/2016

Electronically Signed

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.

Facility ID: 00974

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		LE CONSTRUCTION 02 - 2015 ADDITION	(X3) DATE SURVEY COMPLETED	
		245307	B. WING	_		06/0	07/2016
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa and Angela.Kappenmai		K	000			
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:					
	A description of to correct the deficite	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency					
	buildings: The Cornerstone N built in 1968, is a 1 basement and was (222) construction. basement addition determined to be o In 2016 an addition west wing and was (111) construction	lursing and Rehab Center was -story building, with a partial determined to be of a Type II A 1 story building without was added in 2015 and was f Type V(111) construction. In was added to the end of the determined to be of a Type V and is separated by a 2 hour ldition is fully sprinkled.					
	an automatic sprint accordance with N Installation of Sprin The facility has a fi smoke detection w detection is in all co accordance with N	bletely sprinkler protected with kler system installed in FPA 13 Standard for the akler Systems 1999 edition. The alarm system with corridor ith additional automatic smoke system with system with additional fire edition. All sleeping rooms					

PRINTED: 06/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DESTINAL INCOME.		TIPLE CONSTRUCTION NG 02 - 2015 ADDITION		(X3) DATE SURVEY COMPLETED	
		245307	B. WING		06/0	7/2016	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER				STREET ADDRESS, CITY, STATE, Z 416 SEVENTH STREET NORTHE BAGLEY, MN 56621	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 000	Additional automat all rooms required Code (2007 edition for automatic fire d	age 2 ted smoke detectors installed. ic fire detection is provided in by the Minnesota State Fire a). The fire alarm is monitored department notification. sapacity of 43 beds and had a etime of the survey.	KO	000			
K 025 SS=E	NOT MET as evide NFPA 101 LIFE SA Smoke barriers sh least a one hour fir constructed in acc barriers shall be po	AFETY CODE STANDARD all be constructed to provide at re resistance rating and ordance with 8.3. Smoke ermitted to terminate at an	K	025		7/1/16	
	fire-rated glazing of approved frames. This STANDARD Based on observated determined that the smoke barrier wall 101-2000 edition. This deficient prac- combustion to spre- compartment in the	ows shall be protected by both by wired glass panels in 8.3, 18.3.7.3, 18.3.7.5 is not met as evidenced by: ations and staff interview, it was a facility failed to maintain as in accordance with NFPA Sections 18.3.7.1, 18.3.7.3. Actice could allow the products of ead throughout the smoke a event of a fire which could residents, and an undetermined divisitors.		Cornerstone Nursing ar strives to ensure all smo are constructed to proviresistance rating. On Junoted penetration was prevent the potential spiproducts of combustion smoke compartment. A tiles along both sides of doors were inspected for barrier. Annual smoke have been added to the	bke barrier walls de appropriate fire une 8th, 2016, the properly sealed to read of any throughout the additional ceiling smoke barrier prappropriate barrier inspections		
	on 06/07/2016 obs	between 9:15 am to 1:00 pm servations and staff interview ation above the corridor doors er in the 300 wing near resident	=	Maintenance Log. The Services Supervisor sha for ensuring compliance	Environmental all be responsible		

Facility ID: 00974

FORM CMS-2567(02-99) Previous Versions Obsolete

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

PRINTED: 06/29/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G 02 - 2015 ADDITION		(X3) DATE SURVEY COMPLETED	
		245307	B. WING		06/	07/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	Environmental Ser NFPA 101 LIFE SA Fire drills include the signal and simulating conditions. Fire dritimes under varying on each shift. The and is aware that conducting drills is persons who are of the work of the wore of the work of	dition was verified by the rvices Director. AFETY CODE STANDARD the transmission of a fire alarm on of emergency fire lls are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. It is not met as evidenced by: entation review and staff etermined that the facility failed is in accordance with NFPA Life 200), 18.7.1.2, during the last This deficient practice could fact in the event of a fire. By staff would affect the safety and undetermined amount of the between 9:15 am to 1:00 pm ord review and staff interview drill was missed in the last 12 015.	K 029		drills are parterly on for this and shift. The dar year uded in the trison shall	7/1/16	
K 062	Environmental Se	dition was verified by the rvices Director. AFETY CODE STANDARD	K 06	2		7/1/16	

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

PRINTED: 06/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	(S FOR MEDICARE	= & MEDICAID SERVICES			JIVID NO.	0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - 2015 ADDITION		SURVEY PLETED
		245307	B. WING _		06/0	07/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 062 SS=F	maintained in relia inspected and test 4.6.12, NFPA 13, NThis STANDARD Based on docume with staff, the faciliand maintain the a accordance with NSection 18.7.6, an of Sprinkler Syster for the Inspection, Water Based Fire deficient practice of sprinkler system is fully operational in negatively affect a	r systems are continuously ble operating condition and are ed periodically. 18.7.6, 19.7.6,	K 06	Cornerstone Nursing and Rehablis a fully sprinkler protected facility shall ensure the system is continumaintained in reliable operating of through inspection and testing. For sprinkler water flow tests for this year were reviewed and complete quarterly on each shift. The quarterly on each shift. The quarter flow test policy and proced were reviewed. Documentation of maintained and reviewed by the Environmental Services Supervisions.	y and uously ondition Previous calendar ed terly ures shall be	
K 075 SS=F	on 06/07/2016 recrevealed two quarmissed. 3rd and 4 This deficient prace Environmental Se NFPA 101 LIFE Solied linen or transport exceed 32 gal average density of space shall not exsq.). A capacity of exceeded within a Mobile soiled liner	ctice was verified by the	K 07	75		7/1/16

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

PRINTED: 06/29/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	G 02 - 2015 ADDITION		COMPLETED	
		245307	B. WING		06/0	7/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROD		LD BE	(X5) COMPLETION DATE		
K 075	area when not atte 18.7.5.5, 19.7.5.5 This STANDARD Based on observate facility has failed to carts in properly p with the NFPA 101 edition (LSC) sect practice could afferesidents and an uand visitors if smo carts rendered the Findings include: On the facility tour on 06/07/2016 observealed a trash a 32 gallons was left corridor.	is not met as evidenced by: ations and staff interview, the o store large trash and linen rotected rooms in accordance i "The Life Safety Code" 2000 ion 18.7.5.5. This deficient ect the safety of 9 of the 43 undtermined amount of staff oke or fire from one of these e corridor untenable. The between 9:15 am to 1:00 pm servations and staff interview and soiled linen cart exceeding it unattended in the 300 wing	K 075	Cornerstone Nursing and Rehab strives to ensure a safe and sanit environment by ensuring soiled litrash collection receptacles are sthe designated locations. Nursin personnel were educated on Jun 2016, regarding the designated keep of the carts containing soiled line trash. The nursing assistant orienchecklist was reviewed to ensure appropriate training is given upor orientation. The Environmental Supervisor or designee shall comweekly audits for 4 weeks to ensure compliance.	tary nen and tored in g e 20, ocations n and ntation s Services nplete		

Event ID: UW9B21



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 <u>only a suggestion</u> 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

Cornerstone Nursing and Rehabilitation Center June 22, 2016

Page 2

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

PRINTED: 06/30/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00974 06/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST **CORNERSTONE NSG & REHAB CENTER BAGLEY, MN 56621** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

the Department within 15 days of receipt of a notice of assessment for non-compliance.

You have agreed to participate in the electronic receipt of State licensure orders consistent with

http://www.health.state.mn.us/divs/fpc/profinfo/inf

the Minnesota Department of Health Informational Bulletin 14-01, available at

obul.htm The State licensing orders are delineated on the attached Minnesota

INITIAL COMMENTS:

06/28/16 Electronically Signed

STATE FORM UW9B11 If continuation sheet 1 of 15

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY IPLETED
		00974		B. WING		06 /	/09/2016
	PROVIDER OR SUPPLIER	AB CENTER 4	116 SEVE		STATE, ZIP CODE TT NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to elements of Minnesota Department's and the following corplease indicate in your and identify the date A complaint investige complaint number funsubstantiated. Minnesota Department's sand the following correction that you and identify the date A complaint investige complaint number funsubstantiated. Minnesota Department of State Licensing federal software. The assigned to Minneson Nursing Homes. The assigned tag in column entitled "ID statute/rule out of complaint order. The findings which are in after the statement evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN	Ith orders being submit Although no plan of coate Statutes/Rules, plear rected" in the box avail indicate in the electror cess, under the heading edate your orders will lectronically submitting nent of Health. Ith, and 9th, 2016, survitaff visited the above porrection orders are issured these of the electronic plan of have reviewed these of the ewhen they will be congation was conducted for the ent of Health is docum. Correction Orders using numbers have been so that a state statutes/rules are incompliance is listed in the ent of Deficiencies" coloro Comply" portion of the state of Deficiencies coloro Comply" portion of the state in violation of the state in violation of the state in the surveyors find Method of Correction are rection.	rrection ase able for nic g be to the eyors of rovider ued. rders, npleted. or be nenting ng s for far left e he umn ne es the statute as lings and F THE	2 000			

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 2 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY LETED	
		00974		B. WING		06/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	STONE NSG & REHA	AB CENTER		NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT	ERAL DEFICIE R ON EACH F QUIREMENT T CTION FOR V	PAGE. TO SUBMIT A IOLATIONS OF	2 000			
2 565	MN Rule 4658.0405 Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident	omprehensive personnel inv	plan of care	2 565			7/11/16
	This MN Requirements by: Based on observation review, the facility factor was provided as directed as directed by the control of the control	on, interview a ailed to ensure ected by the c who required as as not provided cility also failed accontinence cat are plan for 1 kk for pressure	and document e oral hygiene are plan for 1 of ssistance with d the d to ensure re was provided of 3 residents ulcers and was		Corrected		
	Findings include:						
	R68 was not provid hygiene as directed						
	R68's Care Plan da required assist of or hygiene.						

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 3 of 15

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00974	B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		
CORNER	RSTONE NSG & REHA	AR CENTER	NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	was observed to pr During the observar place R68's upper of R68's mouth without opportunity to clear teeth prior to the instantial Following the comp NA-D assisted R68 wheeled R68 out of NA-D offer R68 the remaining lower teet inserting the clean of On 6/8/16, at 8:55 at hygiene was not co R68's dentures. NA a mint flavored mouth, however, sh On 6/9/16, at 9:05 at (DON) verified R68 hygiene should have The undated facility indicated a resident	a.m. NA-D verified oral mpleted prior to inserting a-D stated she usually utilized ath swab to cleanse R68's				
	bowel incontinence	repositioning assistance or care as directed by the care and 18 minutes on 6/8/16.				
	staff to turn and rep	ed 3/22/16, directed one-two position and check and change ery two hours in an attempt to rity				

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 4 of 15

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	JLTIPLE CONSTRUCTION DING:	(X	3) DATE SURVEY COMPLETED
		00074	B. WIN	G		00/00/0040
		00974				06/09/2016
NAME OF I	PROVIDER OR SUPPLIER			CITY, STATE, ZIP CODE		
CORNER	RSTONE NSG & REHA	AR CENTER	SEVENTH S SLEY, MN 56	FREET NORTHEAST 621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EIX (EACH CORRECTED CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI EFICIENCY)	
2 565	Continued From pa	age 4	2 565	j		
	enter R6's room an cares. At 8:07 a.m. cares, NE-E and N. wheelchair and wheelchair and wheelchair and wheelchair and wheelchair and wheelchair and was room and assisted and service abdomen and was to the hallway. R6 hallway until 11:20 a.m. NA-A attempted to check abdomen and was to the hallway. R6 hallway until 11:20 a.m. NA-A able to check, chargot up in the mornin R6's bath day and tanything until his beat 11:25 a.m. NA-A toom and transferroof the ceiling lift. Robserved to be dry been incontinent of incontinent brief and buttocks and bony red and his skin was should have been or repositioned every since he was assis and 18 minutes ear	wheeled R6 into the dinin him to eat breakfast. wheeled R6 to the hallwa I until 9:45 a.m. A wheeled R6 to room and thim. R6 struck NA-A in the combative. NA-A returned remained seated in the a.m. A stated they had not beeringe or reposition R6 since ing. NA-A also stated it was they were not able to do ed had been washed. A and NA-C returned R6 to ed him to the bed with the 6's incontinent brief was of urine, however, R6 had stool. NA-A changed R6'd provided perianal care. prominences did not appears intact. NA-A confirmed checked, changed and two hours and had not be ted up in the morning. (3 here)	ning of oom. g y he d R6 he as o his use ls R6's ear R6 en nours			
	reapproach later. It checked back and	NA-A stated she should ha reapproached R6 after 10 ifirmed she had not				

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 5 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00974	B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CORNER	STONE NSG & REHA	AR CENTER	MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 5	2 565			
		and he had gone 3 hours and repositioning, offloading or acontinence.				
	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 care plan would resident's daily care available to staff pe	the Care Plan policy indicated d be used in developing the e routines and would be ersonnel who had responsibility or services to the resident.				
	The director of nursidevelop and impler related to the impler related to oral hygical The DON or designall nursing staff related to a staff related to a staff related to a staff related to the staff	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures ementation of the care plan ene and incontinence care. nee, could provide training for ated to following the care plan. ment and assurance erform random audits to				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			7/11/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the bursing care plan which				

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 6 of 15

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00974	B. WING		06/0	9/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CORNER	RSTONE NSG & REHA	AR CENTER	NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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	without pressure's pressure sores unle condition demonstra authenticates, that B. a resident was received necessar promote healing, promote h	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent veloping. ent is not met as evidenced on, interview and document ailed to ensure timely rovided for 1 of 3 residents sk for the development of a required staff assistance to the development of a required staff assistance to the development of a required staff assistance to the development of a required staff for transfers was totally dependent upon or personal hygiene. The ressure ulcer and required a	2 900	Corrected		

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 7 of 15

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` ′	E CONSTRUCTION		E SURVEY PLETED
		00974		B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CORNE	RSTONE NSG & REHA	AB CENTER			T NORTHEAST		
OOTHITE	ı		-	MN 56621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Catheter Care Area 3/22/16, indicated F development of pre indicated nursing w and toilet R6 as rechours, in conjunction in an attempt to madecrease incontined R6's Skin Risk Assedated 3/18/16, indicated 3/18/16, indicated grequired a turning a R6's Tissue Tolerar indicated R6 require needs every two horepositioned, turned with toileting in atte R6's Care Plan date must anticipate all F Plan also indicated extremities includin hands, especially thor ambulate safely, indicated R6 require turn, reposition and done every two hour on 6/8/16, at 7:52 a was observed to enmorning cares. R6's redness to bony proto strike out and kid maintained a calm a was doing and redii	inence and Indwelling Assessment (CAA) and Was at risk for the source ulcers. The CAO ould continue to check the second and continue to check the second with an offloading so intain skin integrity and episodes. Sessment with Bradent and Easted R6 was at risk for the sessure ulcer and receives for chair and and repositioning programmed as a sist with toward and R6 would be dor offloaded in conjumpt to maintain skin and R6's cares/needs. The R6 had contractures and geformed and continue left and was unable The Care Plan furthed assistance of 1-2 offload and directed	dated AA ck/change y two schedule nd Scale for the quired bed and gram. 6, illeting unction integrity. staff ne Care in all tracted e to stand ier staff to this be at (NA)-E e without observed E what she occurred.	2 900			

Minnesota Department of Health

STATE FORM 6899 UW9B11 If continuation sheet 8 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00974	B. WING		06/0	9/2016
NAME OF P	ROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CORNER	STONE NSG & REH	AR CENTER	MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	R6 was transferred R6 was shaved and was then wheeled of the hallway outside continuously obsert the hallway. -At 9:15 a.m. NA-B room and assisted continuously obsert-At 9:28 a.m. NA-B and he remained so a.m. -At 9:45 a.m. NA-A attempted to check abdomen and was to the hallway. R6 hallway until 11:20 a.m. NA-A able to reposition F morning (3 hours a stated it was R6's to able to do anything been washed. -At 11:25 a.m. NA-A room and transferred of the ceiling lift. R changed and perial buttocks and bony red and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach later. In checked back and minutes. NA-A continuously observed and minutes. NA-A continuously observed and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach later. In checked back and minutes. NA-A continuously observed and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach later. NA-A continuously observed and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach later. NA-A continuously observed and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach. NA-A continuously observed and his skin was should have been rand had not been so on 6/8/16, at 1:04 prombative with care reapproach.	NA-A entered the room and into a wheelchair at 8:07 a.m. doral cares were offered. R6 but of the room and placed in the dining room. R6 was wed seated in his wheelchair in wheeled R6 into the dining him to eat breakfast. R6 was wed seated in the dining room. wheeled R6 to the hallway eated in the hallway until 9:45 wheeled R6 to room and him. R6 struck NA-A in the combative. NA-A returned R6 remained seated in the	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00074	B. WING		00/0	0.4004.0
		00974			06/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CORNER	STONE NSG & REHA	AR CENTER	MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 9	2 900			
	(DON) confirmed R repositioned/offload directed on his care					
	policy, directed staf preventive measure	ention of Pressure Ulcers if general pressure ulcer es included change of position for a person in a chair.				
	The director of nurs develop and impler related to pressure designee, could pro staff related to pres importance of repos assessment and as	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures ulcer prevention. The DON or ovide training for all nursing scure ulcers and the sitioning. The quality scurance committee could idits to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			7/11/16
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	This MN Requirements	ent is not met as evidenced				

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AND DI AN OF CODDECTION IDENTIFICATION NI IMPED:					(3) DATE SURVEY COMPLETED	
00974		B. WING		06/09/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
CORNER	RSTONE NSG & REHA	AB CENTER	NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10	2 920			
	review, the facility f was provided for 1 required assistance the facility failed to care was provided	on, interview and document ailed to ensure oral hygiene of 3 residents (R68) who with oral hygiene. In addition, ensure bowel incontinence for 1 of 3 resident (R6) who staff for assistance.		Corrected		
	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.					
	Assessment (CAA) required extensive grooming, and physical due to impaired bal	tation Potential Care Area dated 4/13/16, indicated R68 assistance with dressing, sical assistance with bathing ance with transfers and recent hospitalization with				
		nted 4/2/16, indicated R68 ne staff to complete oral				
	was observed to pr During the observa place R68's upper of	am. nursing assistant (NA)-D ovide R68 morning cares. tion, NA-D was observed to denture and lower partial into				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00974	B. WING		06/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	STONE NSG & REHA	AR CENTER	NTH STREE MN 56621	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	teeth prior to the insertile properties and freshen the resident's lips and freshen the reside	ase mouth/ brush remaining sertion of the dentures. eletion of the morning cares, into a wheelchair and the room. At no time did opportunity to brush her eth or rinse her mouth prior to dentures. a.m. NA-D verified oral mpleted prior to inserting and the swab to cleanse R68's he forgot to. a.m. the director of nursing 's care plan was correct and should have been provided, by Mouth Care policy indicated at the care was to keep the oral tissue moist, to cleanse sident's mouth, and prevent outh. Brushing Teeth policy is should be assisted with teeth based on his or her	2 920			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED		
		00974		B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CORNE	RSTONE NSG & REHA	AB CENTER		MN 56621	T NORTHEAST		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From participate obstructive pulmonindicated R6 require staff for bed mobility two staff for transfer dependent upon on hygiene. The MDS always incontinent on participate in a continence. R6's Urinary Incont Catheter CAA dated incontinent of bower assistance with tolk CAA indicated R6 wall times and was a a bowel movement assessment period incontinent. The Cawas severely impair candidate for bower further indicated nucheck/change and every 2 hours, in conscience in an attention of the continent of the continent of the continent. The Cawas severely impair candidate for bower further indicated nucheck/change and every 2 hours, in conscience in an attention of the continent of the conti	ary disease. The ed extensive as y, was totally do r and toilet use he staff member of bowel and blooker and linder and blooker most AA indicated R6 red and he was libladder training would contained to maintain a sing would contained to maintain a sing would contained as required and he was libladder training would contained as required and he was libladder training would contained as required as required as required as reasonable as and change a.m. NA-E was hing cares.	he MDS ssistance of two ependent upon and was totally r for personal ed R6 was adder and did m to manage welling ated R6 was and required nobility. The ce products at f to the urge of e MDS times he was 6's cognition and. The CAA ntinue to uested, at least an offloading a skin integrity s. cated staff ds. The plan evel and f of needs. The candidate for tion and e R6 at least observed to	2 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00974		B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNE	RSTONE NSG & REHA	AB CENTER			T NORTHEAST		
	T			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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 920	cares, NA-A and Nawheelchair. R6 was were offered. R6 wand placed in the hroom. Following the continuously observant 9:15 a.m. NA-Broom and assisted continuously observant 9:28 a.m. NA-Bwhere he remained 9:45 a.m. At 9:45 a.m. At 9:45 a.m. At 11:20 a.m. NA-Aattempted to check abdomen and was to the hallway until 11:20 a.m. NA-Aattempted to check, chargot up in the morning bath day and they with him until his beat 11:25 a.m. NA-Aroom and transferred.	A-E transferred R6 is then shaved and was wheeled out of allway outside the expectation, R6 verbeled R6 into the him to eat breakfast ved seated in the day wheeled R6 to the laseated in the hall wheeled R6 to his him. R6 struck Nacombative. NA-A is tated they had not an expectation R6 in the hall wheeled R6 to his laseated in th	oral cares the room dining vas rheelchair. ne dining st. R6 was lining room. hallway vay until s room and A-A in the returned R6 n the ot been 6 since he was R6's anything ed. ed R6 to his	2 920			
	of the ceiling lift. R observed to be dry been incontinent of incontinent brief an buttocks and bony red and his skin was should be checked every two hours an got up in the morninearlier) On 6/8/16, at 1:04 prombative with carreapproach later. In checked back and minutes. NA-A continued to be dry to be desired.	6's incontinent brie of urine, however, stool. NA-A changed provided periana prominences did not intact. NA-A conduction, changed and report dhe had not been ng. (3 hours and 18 po.m. NA-A stated if the she would leave a NA-A stated she she reapproached R6 and a stool of the st	f was R6 had ged R6's I care. R6's ot appear ofirmed R6 ositioned since he minutes R6 was and ould have after 10-15				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ` ′			E SURVEY PLETED	
		00974	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY,			
CORNER	RSTONE NSG & REHA	7R CENTER	SEVENTH STREE GLEY, MN 56621	INORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 14	2 920			
	reapproached R6 a 18 minutes without	and he had gone 3 hours a incontinence care.	and			
	should have been o	a.m. the DON confirmed I checked and incontinent very two hours as directed				
	No policy regarding provided.	bowel incontinence was				
	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.		could ures n could ent			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty	r-one			

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