



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2024

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

RE: CCN: 245307
Cycle Start Date: April 16, 2024

Dear Administrator:

On April 16, 2024, a survey was completed at your facility by the Minnesota Departments of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Midtown Square

3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 16, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 16, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Cornerstone Nsg & Rehab Center

April 25, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2024
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 4/16/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H53072989C (MN102311), with a deficiency cited at F689. H53073241C (MN97760). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p>	F 689		5/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/30/2024
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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 689	<p>Continued From page 1</p> <p>Based on observation, interview and document review the facility failed to ensure policies were consistent with manufacturer's recommendations for use and provide education to staff to reduce the risk for burns related to the use of hot packs for 1 of 1 residents who sustained a superficial burn when a heat pack was placed with out a barrier.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set dated 3/16/24, identified intact cognition. R1's care plan dated 3/28/24, indicated he was able to change position in bed independently. The care plan identified a risk for alteration to skin and indicated he had an abscess to his mons pubis (fatty tissue pad that wraps around the pubic bone).</p> <p>Cornerstone Nursing and Rehab Center Standing Orders dated 1/18/24, indicated: Hot/cold packs, apply for 20 minutes to affected area three times daily as needed for pain/swelling.</p> <p>R1's Resident Progress Notes indicated on 4/7/24, per telephone order from physician, will need following up with primary care physician. Applying heat packs to promote drainage. 4/8/24, Nursing assistant (NA) reported that hot pack was applied to draining wound to mons pubis at HS (hour of sleep). It was reported that hot pack was applied on top of abdominal pad with no barrier causing burns to the skin. Superficial, splotchy raised areas of redness were observed to left and right upper inner thighs and right lower quadrant of abdomen. Areas were not measurable due to irregular edges. Redness to inner thighs was small, pea sized. Lower quadrant of abdomen redness was "roughly" 5</p>	F 689	<p>Cornerstone Nursing and Rehab Center strives to ensure that residents remain free from accidents. R1's reddened area from hot pack application has since healed, R1 is no longer using hot pack applications, and MD was notified of skin concern. An audit has been completed on all residents by reviewing the current census to identify and ensure no other residents have been or will be affected. A PRN order has been added to all current residents using hot packs with follow-up action required. Nurses will be educated at the staff meeting on 5/7/24 on the new PRN order to be utilized for proper documentation and follow-up.</p> <p>The Hot Pack Application policy was updated on 04/23/24 and all Licensed nursing staff will be educated on the new policy and procedure at the staff meeting on 05/07/24, with competency attestation of the new policy by 05/13/24. A written education guide titled "Using Chemical Heat Packs Safely and Effectively" was created for proper hot pack application and monitoring. A competency attestation signature will be completed by 05/13/24 for all Licensed nursing staff. The Director of Nursing or designee shall complete competency audits to ensure proper knowledge of hot pack application through written interviews of Licensed nursing staff pertaining to new Hot Pack application policy. Audits shall be completed three times a week for 2 weeks, twice weekly for 2 weeks, and weekly for 2 weeks, then randomly thereafter. Audit results shall be reviewed at QAPI to determine the need for further</p>	

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F 689	<p>Continued From page 2</p> <p>centimeters (CM) x 4 cm. No blistering noted but R1 did report tenderness to area when it was touched. Will update staff to use hot packs with caution and to use a barrier with application and sit with residents to ensure burns do not occur. 4/8/24, Skin assessed. R1 had three light pink flat areas to lower abdomen consistent with potential burn marks related to hot pack use. Areas measure 3 cm x 1.5 cm, 1.5 cm and 2 cm x .3 cm. No scabbed or blistered areas.</p> <p>Facility policy Hot Pack Application dated 7/1/13, directed staff to wrap the pack in a soft cloth, apply hot pack to desired area and monitor the skin for redness to assure temperature was not too warm. The policy further indicated the instant hot packs did not exceed 122 degrees Fahrenheit and would hold the temperature for approximately 20 minutes.</p> <p>During observation on 4/16/24 at 12:41 p.m., facility staff supplied a hot pack. The hot pack, McKesson Hot Compress was 6 inches by 9 inches and labeled "wrap before applying." The hot pack was further labeled "warning- peak temperature may reach 160 degrees Fahrenheit once activated." Do not place directly on skin. Do not use for more than 30 minutes.</p> <p>During interview on 4/16/24 at 12:30 p.m., licensed practical nurse (LPN)-A stated she had placed the heat pack the evening R1 was burned. LPN-A stated she had placed an abdominal Pad down, a towel and the hot pack. LPN-A stated later one of the nursing assistants (NA)'s called her to R1's room and R1 had some "red lines" on him. LPN-A said she could clearly see the edges of the hot pack and said at that time the hot pack was no longer hot. LPN-A said she felt the red</p>	F 689	monitoring or until compliance is achieved and maintained.	

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F 689	<p>Continued From page 3</p> <p>areas looked like indentations from the edges of the hot pack.</p> <p>During interview on 4/16/24 at 12:41 p.m. registered nurse (RN)-A stated she had seen R1's burn and said it had since healed. RN-A stated the nurse had applied the hot pack without anything under it. RN-B, also present, stated normally the hot packs were placed in a pillow case or something. RN-B stated the person involved had received education.</p> <p>During an interview on 4/16/24 at 3:00 p.m. with the social services designee (SSD) and the administrator, The SSD stated she did not do any of the assessments but said it was hard to determine if the area was a burn. The SSD stated a nurse or two felt like it was the outline of the corners of the hot pack. The SSD said LPN-B had assessed the wound and said she did not think it looked like a burn. The SSD further stated the DON had completed education with the nurse involved and said they were currently reviewing policies. The administrator stated she had mentioned to the DON that maybe they could add some education during the next monthly nurses meeting.</p> <p>During interview on 4/16/24 at 3:22 p.m. LPN-B stated she had looked at R1's wounds but was not sure which date and said she did not document an assessment of the wound. LPN-B said it was red and she felt it was not a burn because it did not blister. LPN-B further stated she felt even if the hot pack was not wrapped in a towel they did not get hot enough to burn, "just my opinion."</p> <p>During interview on 4/16/24 at 3:56 p.m. NA-A</p>	F 689		

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F 689	Continued From page 4 stated she had found the red marks on R1 the night of the incident. NA-A said she had no idea how long the hot pack had been in place. NA-A said she had checked on R1 at one point and he was sitting up in bed eating toast and said she went back about 40 minutes later and saw the corner of a hot pack sticking out. NA-A said she opened the blanket and saw the corners of the hot pack and said the heat pack was on an abdominal dressing, tucked into R1's brief. NA-A stated she had not seen any kind of barrier and said when she removed the hot pack the marks were very visible. NA-A said they had not been there prior to the hot pack being placed.	F 689			



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Electronically delivered

April 25, 2024

Administrator
Cornerstone Nsg & Rehab Center
416 Seventh Street Northeast
Bagley, MN 56621

Re: Event ID: 8B5E11

Dear Administrator:

The above facility survey was completed on April 16, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00974	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2024
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE NSG & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 4/16/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H53072989C (MN102311), H53073241C</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/30/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00974	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2024
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2 000	Continued From page 1 (MN97760). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		