



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
August 23, 2023

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

RE: CCN: 245307  
Cycle Start Date: July 11, 2023

Dear Administrator:

On August 14, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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



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August 23, 2023

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

Re: Reinspection Results  
Event ID: UZXF12

Dear Administrator:

On August 14, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



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July 21, 2023

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

RE: CCN: 245307  
Cycle Start Date: July 11, 2023

Dear Administrator:

On July 11, 2023, a survey was completed at your facility by the Minnesota Department 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, 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](mailto: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 October 11, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 11, 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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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

July 21, 2023

Page 4

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 small dot above the 'i' in Downing.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

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

PRINTED: 08/03/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/11/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE NSG &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621</b>
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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><b>INITIAL COMMENTS</b></p> <p>On 7/7/23, 7/10/23 and 7/11/23, 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. H53073429C (MN94976) H53073430C (MN95005)</p> <p>As a result of the investigation deficiencies were cited at F609 and F610.</p> <p>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 609 SS=D	<p><b>Reporting of Alleged Violations</b> CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2</p>	F 609		8/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/28/2023</b>
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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 609	<p>Continued From page 1</p> <p>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to report an allegation of sexual abuse to the state agency (SA) for 1 of 5 residents (R2) reviewed for abuse and failed to report an incident of resident to resident physical abuse to the SA that resulted in bruising for 1 of 5 residents (R5) reviewed.</p> <p>Findings include:</p> <p>R2's quarterly Minimum Data Set (MDS) dated 5/2/23, identified severe cognitive impairment and indicated she displayed verbal behaviors. The MDS indicated R2 required extensive assistance for locomotion. R2's care plan dated 5/24/23, identified cognitive loss and need for memory care unit. The care plan further identified altered mood related to dementia, anxiety and loss of</p>	F 609	<p>Cornerstone Nursing and Rehab Center has corrected the alleged deficient practice by reporting the event for R2 and R5 to OHFC, along with the completed investigation. The interdisciplinary team has completed audits of all memory care charts as of 7/24/23 to ensure no other residents were affected by the alleged deficient practice.</p> <p>The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur. Education will be provided for all Cornerstone Nursing and Rehab staff regarding Vulnerable Adult policies and procedures, including reporting, by 8/11/23 with a scheduled mandatory in-service on 8/8/23 and 8/9/23. Staff</p>	

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F 609	<p>Continued From page 2</p> <p>autonomy exhibited by physical, verbal aggression or non-aggressive physical and verbal behaviors which included pacing, wandering, restlessness, screaming, cursing, negativism, refusals, yelling and swearing at staff and delusions.</p> <p>R2's facility Progress Notes identified the following:</p> <p>6/13/23, R2 had been yelling at another resident stating, "she is going to kick him in the balls." Staff verbally redirected but behaviors continued.</p> <p>6/13/23, R2 had been pacing the unit and was increasingly agitated and difficult to re-direct. R2 displayed delusional and disorganized thinking and was making accusatory remarks to staff about another resident on the unit. She stated to nursing assistant (NA) about male resident (R4), "I don't like him because he tried to rape me and he's a bad person." The unit was supervised closely 24 hours a day and the accusations did not occur as male resident was in a public area on the unit and out with wife today. Writer immediately updated interim director of nursing (DON) and social service designee (SSD) who collaborated with the administrator about the accusations resident made above to see if further interventions were warranted. Writer was instructed to ensure this residents safety and monitor whereabouts.</p> <p>6/15/23, R2 had been swearing at R4 and telling others he raped her.</p> <p>R5's quarterly MDS dated 5/5/23, identified severe cognitive impairment and indicated she displayed behavior symptoms not directed toward</p>	F 609	<p>unable to attend scheduled education shall receive this education prior to their next scheduled workday.</p> <p>Cornerstone Nursing and Rehab Center's Vulnerable Adult policy and procedure handbook has been reviewed and is accurate. All leadership team members shall receive training through the Vulnerable Adult Mandated Reporter Training through DHS by 8/11/23.</p> <p>Vulnerable adult reporting competency audits shall be completed on 3 randomly selected staff members one time per week for 3 weeks at which time will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee to ensure ongoing compliance. The Interdisciplinary Team members or designee will audit the Facility Activity Report 7x weekly for a period of no less than 4 weeks; then 3x per week for 3 weeks; then 1x per week for 3 weeks to monitor for any potential reportable events and/or investigations. Audit results shall be reviewed at the QAPI committee to determine the need for further monitoring until ongoing compliance is maintained.</p>	

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F 609	<p>Continued From page 3</p> <p>others. R5's care plan dated 5/18/23, identified cognitive loss and a potential for physical and verbal abuse to and from others.</p> <p>R5's facility Progress Notes identified the following:</p> <p>6/14/23, R5 had dark purple bruising to her left forearm that measured 5.5 centimeters (cm) x 4.5 cm. A second noted dated 6/14/23, indicated a new bruise was noted to R5's left forearm from another resident (R2) grabbing R5's arm too hard. The two residents were having a disagreement.</p> <p>6/18/23, R5 had been tearful and frightened trying to get away from R2 as R2 was continually reaching out and trying to grab her. R5 reported that R2 bit her. No biting was witnessed by staff and there had been no opportunity for this to occur. No new bruising or teeth marks noted, only bruising from 6/14/23.</p> <p>During interview on 7/7/23, at 1:03 p.m. the SSD stated she did not feel R2's allegation of sexual assault was reportable and said there had been no opportunity for a sexual assault to occur. The SSD stated she talked to the nurse who said R2 had a history of delusional behaviors and added that she was not aware of R2 having any history of false reporting rape allegations. The SSD said when R2 first began accusing R4, because the unit was so small and so closely monitored she did not feel an opportunity had been present. but no investigation of the allegation had been completed. The SSD stated the altercation between R2 and R5 that resulted in bruising to R5's forearm was not reported. The SSD stated she had asked staff if R2 had been angry with R5</p>	F 609		

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F 609	<p>Continued From page 4</p> <p>and the nurse said R2 did not intend to hurt R5. The SSD said she did not feel the incident was reportable to the SA because there had been no intent to harm even though the progress note indicated the two residents had been having an argument.</p> <p>During interview on 7/7/23, at 1:19 p.m. RN-A stated she had been the interim DON at the time R2 accused R4 of raping her. RN-A stated she had been told the allegation had been reported to the SSD and staff had said there had not been opportunity so the SSD determined the allegation was not reportable and no further investigation was completed.</p> <p>During interview on 7/7/23, at 2:13 p.m. the administrator stated she did not feel the alleged rape had occurred (despite R2 having no history of alleging rape against others and the facility failing to investigate the allegation). The administrator stated as soon as it was reported staff had asked questions and determined it was not reportable and no investigation was needed. In regard to the incident between R2 and R5, the administrator stated the incident had not been reported to the SA because the SSD said R2 did not intend to harm R5.</p> <p>Facility policy Cornerstone Nursing and Rehab Center Vulnerable Adult Policy and Procedures dated 10/10/22, indicated all allegations of abuse are reported no later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not result in serious bodily injury.</p>	F 609		

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F 610 F 610 SS=D	Continued From page 5 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate an allegation of sexual abuse for 1 of 5 residents (R2) reviewed for abuse who alleged rape by another resident (R4).  Findings include:  R2's quarterly Minimum Data Set (MDS) dated 5/2/23, identified severe cognitive impairment and indicated she displayed verbal behaviors. R2's care plan dated 5/24/23, identified cognitive loss and need for memory care unit. The care plan further identified altered mood related to dementia, anxiety and loss of autonomy exhibited by physical, verbal aggression or non-aggressive physical and verbal behaviors which included	F 610 F 610	Cornerstone Nursing and Rehab Center has corrected the alleged deficient practice by reporting the event for R2 to OHFC, along with the completed investigation. The interdisciplinary team has completed audits of all resident charts as of 7/24/23 to ensure no other residents were affected by the alleged deficient practice. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur. Education will be provided for all Cornerstone Nursing and Rehab staff regarding Vulnerable Adult policies and procedures, including reporting, by	8/11/23

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F 610	<p>Continued From page 6</p> <p>pacing, wandering, restlessness, screaming, cursing, negativism, refusals, yelling and swearing at staff and delusions.</p> <p>R2's facility Progress Notes identified the following:</p> <p>6/13/23, R2 had been yelling at another resident stating, "she is going to kick him in the balls." Staff verbally redirected but behaviors continued.</p> <p>6/13/23, R2 had been pacing the unit and was increasingly agitated and difficult to re-direct. R2 displayed delusional and disorganized thinking and was making accusatory remarks to staff about another resident on the unit. She stated to nursing assistant (NA) about male resident (R4), "I don't like him because he tried to rape me and he's a bad person." The unit was supervised closely 24 hours a day and the accusations did not occur as male resident was in a public area on the unit and out with wife today. Writer immediately updated interim director of nursing (DON) and social service designee (SSD) who collaborated with the administrator about the accusations resident made above to see if further interventions were warranted. Writer was instructed to ensure this residents safety and monitor whereabouts.</p> <p>6/15/23, R2 had been swearing at R4 and telling others he raped her.</p> <p>R4's significant change MDS dated 5/19/23, identified severe cognitive impairment and indicated he required limited assistance for ambulation. R4's care plan dated 3/16/23, identified behavioral symptoms not directed toward others that included: hitting or scratching</p>	F 610	<p>8/11/23 with a scheduled mandatory in-service on 8/8/23 and 8/9/23. Staff unable to attend scheduled education shall receive this education prior to their next scheduled workday.</p> <p>Cornerstone Nursing and Rehab Center's Vulnerable Adult policy and procedure handbook has been reviewed and is accurate. All leadership team members shall receive training through the Vulnerable Adult Mandated Reporter Training through DHS by 8/11/23. Abuse Investigation Checklist and Staff Interview Forms have been created; IDT members will be educated on the use of these forms by 8/11/2023 and shall be implemented for all future VA investigations.</p> <p>The Interdisciplinary Team members or designee will audit the Facility Activity Report 7x weekly for a period of no less than 4 weeks; then 3x per week for 3 weeks; then 1x per week for 3 weeks to monitor for any potential reportable events and/or investigations. Audit results shall be reviewed at the QAPI committee to determine the need for further monitoring until ongoing compliance is maintained.</p>	

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

PRINTED: 08/03/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/11/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE NSG &amp; REHAB CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621</b>		
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F 610	<p>Continued From page 7</p> <p>self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes and verbal symptoms.</p> <p>During interview on 7/7/23, at 1:03 p.m. the SSD stated she did not feel R2's allegation of sexual assault was reportable and said there had been no opportunity for a sexual assault to occur. The SSD stated she talked to the nurse who said R2 had a history of delusional behaviors and added that she was not aware of R2 having any history of false reporting rape allegations. The SSD said when R2 first began accusing R4, because the unit was so small and so closely monitored she did not feel an opportunity had been present. but no investigation of the allegation had been completed.</p> <p>During interview on 7/7/23, at 1:19 p.m. RN-A stated she had been the interim DON at the time of the allegation. RN-A stated she had been told the allegation had been reported to the SSD and staff had said there had not been opportunity so the SSD determined the allegation was not reportable and no further investigation was completed.</p> <p>During interview on 7/7/23, at 2:13 p.m. the administrator stated she did not feel the alleged rape had occurred (despite R2 having no history of alleging rape against others and the facility failing to investigate the allegation). The administrator stated as soon as it was reported staff had asked questions and determined it was not reportable and no investigation was needed.</p> <p>Facility policy Cornerstone Nursing and Rehab Center Vulnerable Adult Policy and Procedures</p>	F 610		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 08/03/2023  
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F 610	Continued From page 8 dated 10/10/22, indicated all allegations of abuse would be investigated by the director of social services, DON, administrator or their designees to include interviews with the alleged victim and representative, the alleged perpetrator, witnesses.....	F 610			



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
July 21, 2023

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

Re: State Nursing Home Licensing Orders  
Event ID: UZXF11

Dear Administrator:

The above facility was surveyed on July 7, 2023 through July 11, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Cornerstone Nsg & Rehab Center

July 21, 2023

Page 2

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:

Susie Haben, 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](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00974</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORNERSTONE NSG &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>416 SEVENTH STREET NORTHEAST BAGLEY, MN 56621</b>
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2 000	<p><b>Initial Comments</b></p> <p style="text-align: center;"><b>*****ATTENTION*****</b></p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></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><b>INITIAL COMMENTS:</b> On 7/7/23, 7/10/23 and 7/11/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/28/23</b>
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed. H53073429C (MN94976) H53073430C (MN95005)</p> <p>As a result of the investigation a licensing order was issued at 1980.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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 &lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to</p>	2 000		
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2 000	Continued From page 2  the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21955	MN St. Statute 144A.13 Subd. 2 Complaints; Resident's Rights  Subd. 2. Resident's rights. No controlling person or employee of a nursing home shall retaliate in any way against a complaining nursing home resident and no nursing home resident may be denied any right available to the resident under chapter 504B.  This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of sexual abuse to the state agency (SA) for 1 of 5 residents (R2) reviewed for abuse and failed to report an incident of resident to resident physical abuse to the SA that resulted in bruising for 1 of 5 residents (R5) reviewed.  Findings include:  R2's quarterly Minimum Data Set (MDS) dated 5/2/23, identified severe cognitive impairment and indicated she displayed verbal behaviors. The MDS indicated R2 required extensive assistance	21955	corrected	8/11/23

Minnesota Department of Health

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21955	<p>Continued From page 3</p> <p>for locomotion. R2's care plan dated 5/24/23, identified cognitive loss and need for memory care unit. The care plan further identified altered mood related to dementia, anxiety and loss of autonomy exhibited by physical, verbal aggression or non-aggressive physical and verbal behaviors which included pacing, wandering, restlessness, screaming, cursing, negativism, refusals, yelling and swearing at staff and delusions.</p> <p>R2's facility Progress Notes identified the following:</p> <p>6/13/23, R2 had been yelling at another resident stating, "she is going to kick him in the balls." Staff verbally redirected but behaviors continued.</p> <p>6/13/23, R2 had been pacing the unit and was increasingly agitated and difficult to re-direct. R2 displayed delusional and disorganized thinking and was making accusatory remarks to staff about another resident on the unit. She stated to nursing assistant (NA) about male resident (R4), "I don't like him because he tried to rape me and he's a bad person." The unit was supervised closely 24 hours a day and the accusations did not occur as male resident was in a public area on the unit and out with wife today. Writer immediately updated interim director of nursing (DON) and social service designee (SSD) who collaborated with the administrator about the accusations resident made above to see if further interventions were warranted. Writer was instructed to ensure this residents safety and monitor whereabouts.</p> <p>6/15/23, R2 had been swearing at R4 and telling others he raped her.</p>	21955		
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Minnesota Department of Health

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21955	<p>Continued From page 4</p> <p>R5's quarterly MDS dated 5/5/23, identified severe cognitive impairment and indicated she displayed behavior symptoms not directed toward others. R5's care plan dated 5/18/23, identified cognitive loss and a potential for physical and verbal abuse to and from others.</p> <p>R5's facility Progress Notes identified the following:</p> <p>6/14/23, R5 had dark purple bruising to her left forearm that measured 5.5 centimeters (cm) x 4.5 cm. A second noted dated 6/14/23, indicated a new bruise was noted to R5's left forearm from another resident (R2) grabbing R5's arm too hard. The two residents were having a disagreement.</p> <p>6/18/23, R5 had been tearful and frightened trying to get away from R2 as R2 was continually reaching out and trying to grab her. R5 reported that R2 bit her. No biting was witnessed by staff and there had been no opportunity for this to occur. No new bruising or teeth marks noted, only bruising from 6/14/23.</p> <p>During interview on 7/7/23, at 1:03 p.m. the SSD stated she did not feel R2's allegation of sexual assault was reportable and said there had been no opportunity for a sexual assault to occur. The SSD stated she talked to the nurse who said R2 had a history of delusional behaviors and added that she was not aware of R2 having any history of false reporting rape allegations. The SSD said when R2 first began accusing R4, because the unit was so small and so closely monitored she did not feel an opportunity had been present. but no investigation of the allegation had been completed. The SSD stated the altercation between R2 and R5 that resulted in bruising to</p>	21955		
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Minnesota Department of Health

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21955	<p>Continued From page 5</p> <p>R5's forearm was not reported. The SSD stated she had asked staff if R2 had been angry with R5 and the nurse said R2 did not intend to hurt R5. The SSD said she did not feel the incident was reportable to the SA because there had been no intent to harm even though the progress note indicated the two residents had been having an argument.</p> <p>During interview on 7/7/23, at 1:19 p.m. RN-A stated she had been the interim DON at the time R2 accused R4 of raping her. RN-A stated she had been told the allegation had been reported to the SSD and staff had said there had not been opportunity so the SSD determined the allegation was not reportable and no further investigation was completed.</p> <p>During interview on 7/7/23, at 2:13 p.m. the administrator stated she did not feel the alleged rape had occurred (despite R2 having no history of alleging rape against others and the facility failing to investigate the allegation). The administrator stated as soon as it was reported staff had asked questions and determined it was not reportable and no investigation was needed. In regard to the incident between R2 and R5, the administrator stated the incident had not been reported to the SA because the SSD said R2 did not intend to harm R5.</p> <p>Facility policy Cornerstone Nursing and Rehab Center Vulnerable Adult Policy and Procedures dated 10/10/22, indicated all allegations of abuse are reported no later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not result in serious bodily injury.</p>	21955		
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Minnesota Department of Health

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21955	<p>Continued From page 6</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained.</p> <p><b>TIME PERIOD FOR CORRECTION: 21 DAYS</b></p>	21955		
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