



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 8, 2026

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

RE: CCN: 245307

Cycle Start Date: September 26, 2025

Dear Administrator:

On September 26, 2025, 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 8, 2026

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

Re: Reinspection Results
Event ID: 1D81C2-H1

Dear Administrator:

On December 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 26, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 18, 2025

Administrator

Cornerstone Nursing & Rehab Center

416 SEVENTH STREET NORTHEAST
BAGLEY, MN 56621

RE: CCN:245307

Cycle Start Date: September 26, 2025

Dear Administrator:

On September 26, 2025, 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
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 December 26, 2025(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 26, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution

process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

Feel free to contact me if you have questions.

Sincerely,



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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 18, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D81C2H1

Dear Administrator:

The above facility survey was completed on September 26, 2025 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS On 9/26/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H53075089C (2622124).As a result of the survey a deficiency was issued at F689.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. 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.		F0000			11/18/2025	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to accurately assess pressure ulcers to include type of wound and staging for 2 of 3 residents		F0686	Upon discovery of the deficient practice, the following took place for R2 and R3: For R2 the wound nurse addended the wound assessment and progress note dated 9/25/25 to include proper wound staging. All areas identified as pressure related were restaged and correctly documented, including areas with slough and eschar. R2's care plan was updated to reflect accurate staging, wound etiology, and individualized interventions. Nursing staff involved in documentation for R2 received re-education on proper wound identification and differentiation of pressure injuries vs. dermatitis/MASD (etc.) For R3 the wound nurse addended the wound assessment and added a progress note dated 9/24/25 to include proper wound staging. R3's care plan was revised to include accurate staging and individualized interventions. Nursing staff involved in documentation re-educated on requirement for nursing to identify wound etiology and staging per facility policy and CMS definitions. To ensure no other residents were affected, a facility-wide skin audit was completed and all pressure wounds identified during the audit were assessed for correct staging, etiology, and documentation. Also, any		12/17/2025	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0686 SS = D	Continued from page 1 (R2, R3) reviewed for pressure ulcers. Findings include: R2's Resident Face Sheet indicated she admitted to the facility 7/15/22. Diagnosis included Multiple Sclerosis, depression, spongiatic dermatitis (a skin condition characterized by inflammation and fluid buildup) and anxiety. R2's quarterly Minimum Data Set (MDS) dated 5/21/25, identified intact cognition and indicated she had upper and lower extremity impairments on both sides. The MDS indicated R2 was incontinent of bowel, was dependent on staff for toileting and transfers and had a stage II pressure ulcer (a partial-thickness skin injury that involves damage to the epidermis (outer layer of skin) and some of the dermis (middle layer of skin), present on admission. R2's Tissue Tolerance Test dated 7/16/25, identified a history of pressure ulcers and indicated R2 showed signs of redness at the three-hour mark. Staff to assist with repositioning every two hours and as needed. R2's Braden Scale for Predicting Pressure Ulcer Risk dated 7/30/25, identified high risk for pressure ulcer development. R2's care plan dated 8/14/25, identified a self- care deficit related to impaired mobility, pain, impaired cognition and inability to independently complete activities of daily living. The care plan identified an alteration in elimination, identified the use of a supra-pubic catheter, and bowel incontinence. The care plan further identified an alteration in skin related to impaired mobility and incontinence and indicated she had a chronic ulcer to buttock. The care plan indicated R2 had a stage II pressure sore to her buttock that came and went at baseline and directed staff to float heels, keep skin clean and dry and reposition every 2 – 3 hours in bed. R2's Wound Management Detail Reports identified other dermatitis. 8/19/25, Wound type: Other dermatitis, .08cm x 0.5 cm. wound healing status stable. 8/26/25, Wound type, other dermatitis. Right buttock, 0.8 centimeters (cm) x .5 cm. Wound healing status, stable.		F0686	Continued from page 1 wounds found with incomplete or unclear assessment data were immediately reassessed and corrected by the DON/designee. Systematic changes to prevent recurrence include staff education, process & policy enhancements, and interdisciplinary oversight. Staff Education: All licensed nurses will be educated by 12/10/25 on: CMS pressure injury staging guidelines Differentiating pressure injuries from dermatitis, MASD, shearing, and other skin conditions Requirements for weekly wound documentation, including measurements, tissue type, drainage, edges, and surrounding skin The nurse's responsibility to classify wounds per CMS definitions rather than relying solely on provider diagnosis Competency validation for wound assessment and documentation will be completed for all RNs and LPNs by 12/17/25. Process & Policy Enhancements: The facilities Pressure Ulcers/Skin Breakdown- Clinical Protocol Policy dated 5/17/2019 will be updated by 12/1/25 to clarify: Licensed nurses must accurately stage wounds using CMS pressure injury staging guidelines. Wounds documented as "other dermatitis", or "unspecified ulcer" require documented rationale and must be reviewed by the DON or designee. Any wound presenting with slough, eschar, or purple/maroon discoloration requires immediate DON or designee notification. Interdisciplinary Oversight:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 2 9/11/25, Wound type: other dermatitis. Right buttock 0.5 cm x 0.5 cm. Wound healing status, improving. Open area noted on upper right buttocks. Small blue area noted in the middle. 3.7 cm x 2 cm. 9/17/25, Other dermatitis, 1.2 cm x 1.5 cm, wound status improving, stable. Resident Progress Notes identified the following: 8/6/25, Progress Note indicated R2 had some open areas noted throughout her buttocks. 8/9/25, Progress Notes indicated open sores noted on buttocks, no signs of purulent drainage or foul odor. 8/19/25, Progress Note indicated R2 had two open areas noted to buttocks measuring 0.8 cm x 1.2 cm. below that was 0.5 cm x 0.8 cm to left buttock. 8/26/25, Progress Note indicated R2 had small open areas noted to left buttock. Had a history of opening and closing. 9/5/25, Progress Note indicated R2 had shearing (a type of skin damage that occurs when two layers of skin or tissue slide over each other in opposite directions) noted to left and right inner buttocks. Coccyx had a darkened blue area measuring 1.7 cm x 0.4 cm. 9/11/25, Progress Note indicated R2 had previously open area on left buttock, now healed. Right buttocks had open area noted. Red to wound bed with a blue center noted. Darkened area noted to buttocks measured 11 cm x 9 cm, blanchable. 9/17/25, Progress Note indicated R2 had an open area to right buttock, smaller than previous week. Darkened area to buttock 11 cm x 9 cm, blanchable. 9/26/25, R2's buttock ls macerated throughout. Skin seemed to be very moist. Small scabbed area to the right of the coccyx measuring 0.5cm around. Two smaller open areas to mid left buttock measuring 0.3cm. During observation on 9/26/25 at 1:17 p.m., with the director of nursing (DON), R2 was lying in bed. R2's buttocks had a darkened area approximately 6 inches x 6 inches. R2's buttocks was macerated with open areas present. On the right side of the coccyx were two small dark eschar (a patch of dead, dry, leathery tissue that forms over a wound bed, typically appearing black or dark brown and firmly attached to the underlying skin. Unlike a scab, which protects a superficial injury, an			F0686	Continued from page 2 The DON or designee will collaborate with dietary, therapy and nursing during weekly wound rounds to ensure comprehensive care plans are reflective of residents' needs and wound progression. To ensure ongoing compliance the DON or designee will complete weekly audits of all residents with pressure injuries for four weeks, every other week for four weeks, and then monthly for two months, using the Wound Assessment Audit Tool. Audits will verify correct staging and etiology; accurate and complete weekly documentation; appropriate interventions and treatment orders and care plan accuracy. The results of the audits will be reviewed with the QAPI committee to identify potential trends and opportunities for improvement.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 3 eschar is a sign of non-viable tissue resulting from severe burns, pressure ulcers, infections, or other trauma) areas on the upper right side of the wound. The DON stated the wound on the right side of R2's coccyx was pressure related. On the top left side of R2's coccyx was a small area covered in slough (type of non-viable dead tissue that forms in wounds. It is typically yellow, white, or gray in color and has a soft, moist, or stringy texture.) The DON stated the wound was also pressure related but was unable to stage the wound. R3's Resident Face Sheet indicated she admitted to the facility 6/8/2006. Diagnosis included Multiple Sclerosis, chronic osteomyelitis of right thigh, diabetes mellitus and stage IV pressure ulcer (a severe form of pressure injury that involves deep tissue damage, exposing muscle, tendon, or bone) of right buttock. R3's Tissue Tolerance Test dated 2/18/25, indicated a history of pressure ulcers and indicated she showed signs of redness over bony prominences at the three-hour mark. Staff to assist with turning and repositioning every two hours and as needed. R3's Braden Scale for Predicting Pressure Ulcer Risk dated 8/6/25, indicated moderate risk for pressure ulcer development. R3's quarterly MDS dated 8/6/25, identified moderate cognitive impairment and indicated she had lower extremity impairments on both sides. The MDS indicated R3 was dependent on staff for toileting and transfers and had a stage IV pressure ulcer present on admission. R3's care plan dated 8/25/25, identified impaired mobility related to a need for assistance from staff for all cares. The care plan indicated R3 was non-weight bearing and required assistance for toileting and repositioning. The care plan identified bowel incontinence, the use of an indwelling catheter and a risk for pressure ulcers related to a history of pressure ulcer to coccyx area and current pressure ulcer to right upper thigh/buttock. The care plan directed staff to assist to turn and reposition every two hours. R3's Wound Management Detail Reports identified the following: Unspecified ulcer: 9/11/25, 2.5 cm x 1 cm, tissue type: slough, Moderate			F0686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0686 SS = D	Continued from page 4 serosanguineous drainage (red to pale pink, thin and watery), surrounding tissue redness/blanchable; pink/normal. Wound healing status, stable. 9/17/25, 3.5 cm x .5 cm, light serosanguinous drainage. Tissue type slough, surrounding tissue blanchable redness. 9/24/25, .2 cm x .8 cm. Moderate serosanguinous drainage. Tissue type, granulation tissue, edges rolled/thickened. Surrounding tissue blanchable redness. R3's Resident Progress Notes indicated the following: 8/19/25, Wound bed to right buttock has granulation tissue with slough noted to the edges. Moderate serosanguinous drainage noted. Skin surrounding wounds has blanchable redness. Coccyx is healing well, fragile pink skin to be sheared off slightly. Left thigh is closed. 8/26/25, R2's wound bed to right buttock had granulation tissue present with slough noted on the edges. Moderate serosanguinous drainage noted. Coccyx is healing well, fragile skin noted, looked to be sheared off slightly. Left thigh is closed. 9/11/25, Wound bed to right buttock has granulation tissue present with slough noted at the edges. Moderate serosanguinous drainage noted. Wound below previous wound is flush with skin, wound bed has white tissues. Surrounding tissue has blanchable redness. Left thigh is closed. Coccyx is open, wound bed pink/red with moderate amount of serosanguinous drainage noted. 9/17/25, Progress Note indicated R3's wound bed to right buttocks had granulation tissue present with slough noted to the edges. Moderate serosanguineous drainage noted. Coccyx is open, wound bed is pink/red with slough noted to center with moderate amounts of serosanguinous drainage noted. During interview on 9/26/25 at 1:07 p.m., when asked why R3's wound documentation identified unspecified ulcer, the DON stated they did not diagnose and said the type of ulcer was whatever the provider said it was. During observation on 9/26/25 at 2:03 p.m., R3 was in bed. R3 had an open area just above her coccyx approximately 1 cm. R3's right gluteal fold had a large deep area with a combination of granulation tissue and slough.		F0686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 5 During interview on 9/26/25 at 3:07 p.m., the DON stated the facility used the Center for Medicare & Medicated (CMS) wound guidelines when staging a wound. Facility Policy Wound Care dated 5/20/19, indicated the following should be recorded in the resident's medical record: Type of wound care given, time wound care was given, any change in resident condition, all assessment data (i.e., wound bed, color, size, drainage, etc.) at minimum weekly.			F0686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS On 9/26/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H53075089C (2622124).As a result of the survey a deficiency was issued at F689.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. 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.		F0000			11/18/2025	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to accurately assess pressure ulcers to include type of wound and staging for 2 of 3 residents		F0686	Upon discovery of the deficient practice, the following took place for R2 and R3: For R2 the wound nurse addended the wound assessment and progress note dated 9/25/25 to include proper wound staging. All areas identified as pressure related were restaged and correctly documented, including areas with slough and eschar. R2's care plan was updated to reflect accurate staging, wound etiology, and individualized interventions. Nursing staff involved in documentation for R2 received re-education on proper wound identification and differentiation of pressure injuries vs. dermatitis/MASD (etc.) For R3 the wound nurse addended the wound assessment and added a progress note dated 9/24/25 to include proper wound staging. R3's care plan was revised to include accurate staging and individualized interventions. Nursing staff involved in documentation re-educated on requirement for nursing to identify wound etiology and staging per facility policy and CMS definitions. To ensure no other residents were affected, a facility-wide skin audit was completed and all pressure wounds identified during the audit were assessed for correct staging, etiology, and documentation. Also, any		12/17/2025	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0686 SS = D	Continued from page 1 (R2, R3) reviewed for pressure ulcers. Findings include: R2's Resident Face Sheet indicated she admitted to the facility 7/15/22. Diagnosis included Multiple Sclerosis, depression, spongiatic dermatitis (a skin condition characterized by inflammation and fluid buildup) and anxiety. R2's quarterly Minimum Data Set (MDS) dated 5/21/25, identified intact cognition and indicated she had upper and lower extremity impairments on both sides. The MDS indicated R2 was incontinent of bowel, was dependent on staff for toileting and transfers and had a stage II pressure ulcer (a partial-thickness skin injury that involves damage to the epidermis (outer layer of skin) and some of the dermis (middle layer of skin), present on admission. R2's Tissue Tolerance Test dated 7/16/25, identified a history of pressure ulcers and indicated R2 showed signs of redness at the three-hour mark. Staff to assist with repositioning every two hours and as needed. R2's Braden Scale for Predicting Pressure Ulcer Risk dated 7/30/25, identified high risk for pressure ulcer development. R2's care plan dated 8/14/25, identified a self-care deficit related to impaired mobility, pain, impaired cognition and inability to independently complete activities of daily living. The care plan identified an alteration in elimination, identified the use of a supra-pubic catheter, and bowel incontinence. The care plan further identified an alteration in skin related to impaired mobility and incontinence and indicated she had a chronic ulcer to buttock. The care plan indicated R2 had a stage II pressure sore to her buttock that came and went at baseline and directed staff to float heels, keep skin clean and dry and reposition every 2 – 3 hours in bed. R2's Wound Management Detail Reports identified other dermatitis. 8/19/25, Wound type: Other dermatitis, .08cm x 0.5 cm. wound healing status stable. 8/26/25, Wound type, other dermatitis. Right buttock, 0.8 centimeters (cm) x .5 cm. Wound healing status, stable.		F0686	Continued from page 1 wounds found with incomplete or unclear assessment data were immediately reassessed and corrected by the DON/designee. Systematic changes to prevent recurrence include staff education, process & policy enhancements, and interdisciplinary oversight. Staff Education: All licensed nurses will be educated by 12/10/25 on: CMS pressure injury staging guidelines Differentiating pressure injuries from dermatitis, MASD, shearing, and other skin conditions Requirements for weekly wound documentation, including measurements, tissue type, drainage, edges, and surrounding skin The nurse's responsibility to classify wounds per CMS definitions rather than relying solely on provider diagnosis Competency validation for wound assessment and documentation will be completed for all RNs and LPNs by 12/17/25. Process & Policy Enhancements: The facilities Pressure Ulcers/Skin Breakdown- Clinical Protocol Policy dated 5/17/2019 will be updated by 12/1/25 to clarify: Licensed nurses must accurately stage wounds using CMS pressure injury staging guidelines. Wounds documented as "other dermatitis", or "unspecified ulcer" require documented rationale and must be reviewed by the DON or designee. Any wound presenting with slough, eschar, or purple/maroon discoloration requires immediate DON or designee notification. Interdisciplinary Oversight:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 2 9/11/25, Wound type: other dermatitis. Right buttock 0.5 cm x 0.5 cm. Wound healing status, improving. Open area noted on upper right buttocks. Small blue area noted in the middle. 3.7 cm x 2 cm. 9/17/25, Other dermatitis, 1.2 cm x 1.5 cm, wound status improving, stable. Resident Progress Notes identified the following: 8/6/25, Progress Note indicated R2 had some open areas noted throughout her buttocks. 8/9/25, Progress Notes indicated open sores noted on buttocks, no signs of purulent drainage or foul odor. 8/19/25, Progress Note indicated R2 had two open areas noted to buttocks measuring 0.8 cm x 1.2 cm. below that was 0.5 cm x 0.8 cm to left buttock. 8/26/25, Progress Note indicated R2 had small open areas noted to left buttock. Had a history of opening and closing. 9/5/25, Progress Note indicated R2 had shearing (a type of skin damage that occurs when two layers of skin or tissue slide over each other in opposite directions) noted to left and right inner buttocks. Coccyx had a darkened blue area measuring 1.7 cm x 0.4 cm. 9/11/25, Progress Note indicated R2 had previously open area on left buttock, now healed. Right buttocks had open area noted. Red to wound bed with a blue center noted. Darkened area noted to buttocks measured 11 cm x 9 cm, blanchable. 9/17/25, Progress Note indicated R2 had an open area to right buttock, smaller than previous week. Darkened area to buttock 11 cm x 9 cm, blanchable. 9/26/25, R2's buttock ls macerated throughout. Skin seemed to be very moist. Small scabbed area to the right of the coccyx measuring 0.5cm around. Two smaller open areas to mid left buttock measuring 0.3cm. During observation on 9/26/25 at 1:17 p.m., with the director of nursing (DON), R2 was lying in bed. R2's buttocks had a darkened area approximately 6 inches x 6 inches. R2's buttocks was macerated with open areas present. On the right side of the coccyx were two small dark eschar (a patch of dead, dry, leathery tissue that forms over a wound bed, typically appearing black or dark brown and firmly attached to the underlying skin. Unlike a scab, which protects a superficial injury, an			F0686	Continued from page 2 The DON or designee will collaborate with dietary, therapy and nursing during weekly wound rounds to ensure comprehensive care plans are reflective of residents' needs and wound progression. To ensure ongoing compliance the DON or designee will complete weekly audits of all residents with pressure injuries for four weeks, every other week for four weeks, and then monthly for two months, using the Wound Assessment Audit Tool. Audits will verify correct staging and etiology; accurate and complete weekly documentation; appropriate interventions and treatment orders and care plan accuracy. The results of the audits will be reviewed with the QAPI committee to identify potential trends and opportunities for improvement.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0686 SS = D	Continued from page 3 eschar is a sign of non-viable tissue resulting from severe burns, pressure ulcers, infections, or other trauma) areas on the upper right side of the wound. The DON stated the wound on the right side of R2's coccyx was pressure related. On the top left side of R2's coccyx was a small area covered in slough (type of non-viable dead tissue that forms in wounds. It is typically yellow, white, or gray in color and has a soft, moist, or stringy texture.) The DON stated the wound was also pressure related but was unable to stage the wound. R3's Resident Face Sheet indicated she admitted to the facility 6/8/2006. Diagnosis included Multiple Sclerosis, chronic osteomyelitis of right thigh, diabetes mellitus and stage IV pressure ulcer (a severe form of pressure injury that involves deep tissue damage, exposing muscle, tendon, or bone) of right buttock. R3's Tissue Tolerance Test dated 2/18/25, indicated a history of pressure ulcers and indicated she showed signs of redness over bony prominences at the three-hour mark. Staff to assist with turning and repositioning every two hours and as needed. R3's Braden Scale for Predicting Pressure Ulcer Risk dated 8/6/25, indicated moderate risk for pressure ulcer development. R3's quarterly MDS dated 8/6/25, identified moderate cognitive impairment and indicated she had lower extremity impairments on both sides. The MDS indicated R3 was dependent on staff for toileting and transfers and had a stage IV pressure ulcer present on admission. R3's care plan dated 8/25/25, identified impaired mobility related to a need for assistance from staff for all cares. The care plan indicated R3 was non-weight bearing and required assistance for toileting and repositioning. The care plan identified bowel incontinence, the use of an indwelling catheter and a risk for pressure ulcers related to a history of pressure ulcer to coccyx area and current pressure ulcer to right upper thigh/buttock. The care plan directed staff to assist to turn and reposition every two hours. R3's Wound Management Detail Reports identified the following: Unspecified ulcer: 9/11/25, 2.5 cm x 1 cm, tissue type: slough, Moderate		F0686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0686 SS = D	Continued from page 4 serosanguineous drainage (red to pale pink, thin and watery), surrounding tissue redness/blanchable; pink/normal. Wound healing status, stable. 9/17/25, 3.5 cm x .5 cm, light serosanguinous drainage. Tissue type slough, surrounding tissue blanchable redness. 9/24/25, .2 cm x .8 cm. Moderate serosanguinous drainage. Tissue type, granulation tissue, edges rolled/thickened. Surrounding tissue blanchable redness. R3's Resident Progress Notes indicated the following: 8/19/25, Wound bed to right buttock has granulation tissue with slough noted to the edges. Moderate serosanguinous drainage noted. Skin surrounding wounds has blanchable redness. Coccyx is healing well, fragile pink skin to be sheared off slightly. Left thigh is closed. 8/26/25, R2's wound bed to right buttock had granulation tissue present with slough noted on the edges. Moderate serosanguinous drainage noted. Coccyx is healing well, fragile skin noted, looked to be sheared off slightly. Left thigh is closed. 9/11/25, Wound bed to right buttock has granulation tissue present with slough noted at the edges. Moderate serosanguinous drainage noted. Wound below previous wound is flush with skin, wound bed has white tissues. Surrounding tissue has blanchable redness. Left thigh is closed. Coccyx is open, wound bed pink/red with moderate amount of serosanguinous drainage noted. 9/17/25, Progress Note indicated R3's wound bed to right buttocks had granulation tissue present with slough noted to the edges. Moderate serosanguineous drainage noted. Coccyx is open, wound bed is pink/red with slough noted to center with moderate amounts of serosanguinous drainage noted. During interview on 9/26/25 at 1:07 p.m., when asked why R3's wound documentation identified unspecified ulcer, the DON stated they did not diagnose and said the type of ulcer was whatever the provider said it was. During observation on 9/26/25 at 2:03 p.m., R3 was in bed. R3 had an open area just above her coccyx approximately 1 cm. R3's right gluteal fold had a large deep area with a combination of granulation tissue and slough.		F0686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2025	
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center				STREET ADDRESS, CITY, STATE, ZIP CODE 416 SEVENTH STREET NORTHEAST , BAGLEY, Minnesota, 56621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 5 During interview on 9/26/25 at 3:07 p.m., the DON stated the facility used the Center for Medicare & Medicated (CMS) wound guidelines when staging a wound. Facility Policy Wound Care dated 5/20/19, indicated the following should be recorded in the resident's medical record: Type of wound care given, time wound care was given, any change in resident condition, all assessment data (i.e., wound bed, color, size, drainage, etc.) at minimum weekly.			F0686			