Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2023

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

RE: CCN: 245307
Cycle Start Date: April 19, 2023

Dear Administrator:

On May 2, 2023, we notified you a remedy was imposed. On May 23, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 9, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 2, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 19, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2023

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

Re: Reinspection Results
Event ID: PG9B12

Dear Administrator:

On May 23, 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 April 19, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
May 2, 2023

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

RE: CCN: 245307
Cycle Start Date: April 19, 2023

Dear Administrator:

On April 19, 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On April 6, 2023, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. Because corrective action was taken prior to the survey, F678 is being cited as past non-compliance.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 19, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 19, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 19, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Cornerstone Nsg & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 19, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 19, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: PG9B11

Dear Administrator:

The above facility was surveyed on April 18, 2023 through April 19, 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. 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/18/23-4/19/23, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed. H53079981C (MN00092478) and a deficiency was issued at F678 at PAST NON-COMPLIANCE; H53071404C (MN00085637). As a result of the investigation, a deficiency was also issued at F609. 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		5/9/23

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

Electronically Signed | 05/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 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. §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 ensure timely (2 hours) reporting to the State Agency for 1 of 1 resident (R1) who was deprived of cardiopulmonary resuscitation (CPR) against the resident's wishes. Findings include: R1's face sheet showed an admission date of 8/21/19, with full code status. R1's Provider Orders for Life Sustaining Treatment (POLST) signed by R1's representative on 8/21/19, indicated R1's wish for staff members to attempt resuscitation/CPR in the event of cardiopulmonary arrest (heart stops). R1's progress notes showed that on 4/2/23, at about 1:20 a.m., licensed practical nurse (LPN)-A assessed R1 having no pulse and no breathing. LPN-A called LPN-B to R1's room, where LPN-B	F 609	Cornerstone Nursing and Rehab Center shall provide timely reporting to the Administrator of the facility and to other officials, of alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. On 4/3/23, a vulnerable adult report was filed with the State agency for R1 and the Administrator was notified. The investigative report was completed and filed with the State agency and appropriate interventions were immediately put into place. No other residents were found to have been affected and to ensure this deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 helped nursing assistant (NA)-A to clean up R1. There was a lack of documentation or evidence to show that a staff member started CPR for R1. On 4/18/23, at 1:12 p.m. LPN-B indicated she went to R1's room on 4/2/23, at about 1:30 a.m. and saw that R1 "obviously passed away." LPN-B acknowledged that she did not initiate CPR saying R1 was not under her care. On 4/18/23, at 1:27 p.m., LPN-A stated that on 4/2/23, NA-A called her into R1's room, where she found R1 unresponsive. LPN-A also stated she went out from R1's room to secure stethoscope, call LPN-B, and then went back to assess R1. LPN-A indicated she auscultated for breath sounds but heard nothing, and that R1's legs were splotchy, mottling, cold and stiff when picked up. LPN-B stated she "freaked out" and did not start CPR. During an interview on 4/18/23, at 2:39 p.m., the administrator stated that they (administrator, the social service designee [SSD], and the director of nursing [DON]) were not notified about the incident until the morning of 4/2/23, and that SSD was the one who talked to the staff members thereafter. During an interview on 4/18/23, at 2:39 p.m., the DON stated expectation for staff members to provide CPR in a situation like R1's case. The DON added, "I would be surprised if rigor set in that fast." An incident report regarding the failure to provide CPR to R1 was reported to the Minnesota Department of Health on 4/3/23 at 2:58 p.m., more than 37 hours after the incident.	F 609	practice doesn't recur, the following measures have been implemented. The facility's Vulnerable Adult policy and procedures were reviewed by the Administrator and Social Services Designee which was current and accurate, and no changes necessary. Education was provided to all staff beginning on 4/24/23 on Cornerstone Nursing and Rehab Center's Vulnerable Adult policy and procedures which includes the requirements of the reporting timeframe. An acknowledgment of the review and understanding accompanied the policy and procedures for all staff to sign. All new hires shall be orientated on the facility's VA policy and procedures. The VA binder which includes the policy and procedures are maintained at the nurses' stations for reference to all staff. Social Services or designee shall complete random audits of staff members to ensure ongoing understanding of reporting procedures. Audits shall consist of interviewing three staff members three times a week for four weeks, then 3 staff members weekly for two additional months. Audit results shall be reviewed at Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring until compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 The facility's policy titled, Vulnerable Adult Policy and Procedures, with the most recent revision history dated 10/10/22, included in its objectives to protect the health, welfare, and rights of its residents by prohibiting and preventing neglect. The policy directed staff to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately, not later than 2 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 and other officials. The policy directed the DON or SSD to file or contact the designee to file and complete the Minnesota Department of Health Vulnerable Adult online incident report within the required timeframe.	F 609		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST) in order to provide cardiopulmonary resuscitation (CPR) for 1 of 3 residents (R1) in the sample reviewed, who wished to have CPR in the event of cardiopulmonary arrest (where resident has no	F 678	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 4	F 678		

pulse and is not breathing).

The immediate jeopardy (IJ) began on 4/2/23, at approximately 1:20 a.m. when licensed practical nurse (LPN)-A entered R1's room and found R1 having no respirations and no pulse, however, CPR was not initiated, contrary to R1's wish. The IJ was identified on 4/19/23, and the administrator was notified of the IJ on 4/19/23, at 11:20 a.m. The IJ was removed on 4/6/23, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.

Findings include:

R1's face sheet indicated an admission date of 8/21/19, with full code status. R1's POLST document, signed and dated 8/21/19, directed staff members to attempt resuscitation/CPR in the event of cardiopulmonary arrest (heart stops).

R1's annual Minimum Data Set (MDS) dated 3/20/23, indicated R1 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15.

R1's progress notes showed a care conference between R1 and the interdisciplinary team (IDT) on 3/30/23, where R1's code status was reviewed, and as noted, "resident requests to remain full code."

R1's progress notes (unedited) showed an entry on 4/2/23, at 2:38 a.m. which indicated nursing assistant (NA)-A called LPN-A into R1's room at 1:20 a.m. where LPN-A described R1 as having no color and was not breathing. LPN-A noted having auscultated R1's apical pulse for 1 full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 5	F 678		

minute and then called the other nurse (LPN-B). LPN-A also noted "orange foul smelling liquid run out of [R1's] mouth" with head in an "elevated" position and turned to side due to "vomiting so much lately and earlier tonight."

R1's progress notes (edited) on 4/2/23, at 10:31 p.m. indicated that in response to NA's call, LPN-A entered R1's room and as noted, "knew by looking at [R1] was deceased, color was drained from face, mouth hanging open, it was 1:20." LPN-A also noted having left the room to grab equipment and call the other nurse. LPN-A noted her assessments as "Warm to touch on the arm, cold to touch on lower part of body as well as mottling from feet to the stomach, at that time it was noted that rigor mortis had set in. No lung sounds present."

During interview on 4/18/23, at 12:11 p.m. NA-A stated that on 4/2/23, after 1:00 a.m. she entered R1's room to stock briefs and discovered R1 having "obviously vomited at some point" and was unresponsive. NA-A said she was not sure if the vomiting was after R1 passed but that she reported the observation to licensed practical nurse (LPN)-A, who then went to the room. LPN-B also arrived at the room and helped NA-A clean up R1. NA-A said that while they were cleaning R1, there was more orange-colored liquid that poured out of (R1's) mouth.

During interview on 4/18/23, at 12:31 p.m. NA-B said she worked the evening shift (starting at 5:00 p.m.) on 4/1/23. NA-B indicated she took care of R1 during that time and observed R1 to be weak and sick. NA-B also said R1 vomited and had diarrhea between 6:00 p.m. and 7:00 p.m., which she reported to LPN-A. NA-B further stated R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 6	F 678		

had been using call light to ask for help with little things, with the last call made between 11:00 p.m. and 12:00 a.m., when R1 asked to lie down but she discouraged the idea because of R1's vomiting. NA-B added, the last time she was in R1's room that night was between 12:30 a.m. and 1:00 a.m., where she saw R1 asleep, pale but breathing fine.

During interview on 4/18/23, at 1:12 p.m. LPN-B stated at about 1:30 a.m. on 4/2/23, she went to R1's room to help. LPN-B stated, "[R1] obviously passed away when I went to the room." LPN-B stated she was not aware of R1's code status at the time she went to help and acknowledged that she did not do CPR. LPN-B said that if R1 was under her care or if R1 was her resident, she would have administered CPR until EMS arrived. LPN-B also said that administering CPR for R1 "was the other nurse's call." LPN-B further said, "Clearly [R1] was deceased but if [R1] was my patient I would have just performed CPR, that was what we have always been told."

During interview on 4/18/23, at 1:27 p.m. LPN-A stated that on 4/1/23, she went to check on R1 between 6:00 p.m. and 7:00 p.m. for medication administration and to start the resident's tube feeding, and described R1 as fine at that time. LPN-A said she knew that R1 had been sick and vomiting that evening. LPN-A also indicated she went to stop R1's feeding at about 9:30 p.m. due to R1 experiencing more vomiting. LPN-A further indicated she went to R1's room at midnight (4/2/23 at about 12:01 a.m.) for rounds and saw R1 sleeping so she did not bother R1, however, at about 1:15 a.m., NA-A called her to R1's room saying that R1 was "gone." LPN-A said when she went to the room, R1 was "obviously deceased,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 7 rigor mortis had set-in, and had pale face." LPN-A said she went out to the nurse's station, took a stethoscope, called the other nurse (LPN-B) and then returned to R1's room. LPN-A indicated she auscultated R1 for breath sounds and heard nothing. LPN-A stated she pulled back R1's blankets and R1's legs were splotchy, mottling, cold and stiff when picked up, adding she never touched the upper extremities. LPN-A further stated that she did not know R1's code status at that time and that if she knew she would have told NA-A to go get the other nurse and would have started chest compressions. LPN-A acknowledged that when in doubt, CPR would normally be initiated. LPN-A further acknowledged that she did not start CPR for R1. When asked why CPR was not initiated, LPN-A replied, "I think I just freaked out." LPN-A also verified that she did not call 911 at any point. During interview on 4/18/23, at 2:39 p.m., the administrator stated that they (the administrator, the social service designee [SSD], and the director of nursing [DON], who were all present at this time of interview) were not notified about the incident until the morning of 4/2/23, and that it was the SSD who talked to the staff thereafter. The SSD stated she talked to LPN-A after having been notified and LPN-A was "very specific on the fact that [R1] was deceased." The SSD also said she then told LPN-A "to document" what she saw when she found R1. The SSD reported she was not sure what time LPN-A documented. When asked if staff followed facility's policy and procedure, the SSD replied, "what we did was chart review per documentation and the regulation, and the documentation said [R1] was cold, and rigor had set in."	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 8	F 678		

When the director of nursing (DON) was asked about her expectations on how staff members should act in a situation like that, the DON stated, "My expectation would be for them to provide CPR. I would be surprised if rigor set in that fast."

The facility's staffing schedule sheet from 4/1/23 to 4/3/23 indicated that LPN-A and LPN-B worked when the incident occurred on 4/1/23, and on 4/2/23, after the incident.

The facility's Progressive Discipline Notification forms showed that disciplinary actions were issued to LPN-A and LPN-B on 4/5/23 and 4/6/23, respectively for failure to provide CPR to R1, who was a full code status.

During interview on 4/19/23, at 8:46 a.m. the DON verified that LPN-A and LPN-B worked their regular schedules on the night of 4/2/23, despite the incident regarding failure to provide CPR for R1 on 4/1/23. The DON acknowledged that both nurses did not undergo education/training and were not disciplined until 4/5/23 and 4/6/23. The DON also stated that she started educating all other licensed staff (nurses) about the facility's policies and updated procedure regarding CPR, and calling emergency medical services.

During an interview on 4/18/23, at 2:15 p.m. LPN-C stated she would always check for the code status of her residents and indicated that she would perform CPR until EMS arrives to take over on Full Code residents. LPN-C also indicated having met with the SSD, where she was educated on what to do in similar cases and also about residents' POLST, which were now posted inside residents' closets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 9 During an interview on 4/19/23, at 9:45 a.m., LPN-D stated she would check the residents code status perform CPR to a full code resident when found unresponsive until paramedics take over. When asked if there would be a situation where she would not perform CPR to a full code resident, LPN-D stated, "When they are full code, they are full code." Additionally, LPN-D stated she recently received education from the facility on the CPR policy and revisions that were made. The facility's policy titled, Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS), with review date of 8/29/22, indicated the goal of early delivery of CPR is to try to maintain life until the emergency medical response team arrives to deliver Advanced Life Support (ALS). The policy directed licensed staff person/s to deliver CPR if a resident is found unresponsive and without a pulse, unless the resident is known to have a Do Not Resuscitate (DNR) order or specific prohibition of CPR in his/her POLST; or when there are signs of irreversible death. The CPR procedure listed directions to include checking the resident for no pulse and no respirations; activate the emergency response team and initiate CPR (notify staff of code situation and designate a staff to call 911 and then contact the resident's attending physician and the resident's family); open airway; check breathing; administer rescue breaths; check for pulse; give chest compressions. In addition, the procedure directed the staff members to document in the resident's medical records the following: the condition in which the resident was found; the sequence of resuscitation efforts and times; the resident's response to resuscitation efforts; the approximate time that the emergency medical services (EMS) took over; and the time	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. BUILDING _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 10 of death. The past noncompliance immediate jeopardy (IJ) began on 4/2/23. The IJ was removed, and the deficient practice corrected by 4/6/23, after the facility implemented a systemic plan that included the following actions: -Educated LPN-A and LPN-B regarding provision of CPR to full code residents. -Issued disciplinary actions to LPN-A and LPN-B on 4/5/23 and 4/6/23, respectively, for failure to initiate CPR for a full code resident. -Posted the code status inside the closets of residents. -Revised the CPR policy to include direction for the admit nurse to update closet with code status, initial, and date. If there is a change in code, primary nurse will update chart and closet. In addition, the updated policy directed staff to call the code situation by calling "code blue" over the walkies (hand held communication device). -Developed policy titled, Handoff Communication that includes residents' code status information when giving reports between caregivers. --Interviews with staff nurses on 4/18/23 and 4/19/23 confirmed the facility's policies and procedures will be followed.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/18/23-4/19/23, 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 have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53079981C (MN00092478) H53071404C (MN00085637) As a result of the investigation, a licensing order was issued at 1995. 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. 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/ib14_1.html 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure timely (2 hours) reporting to the State Agency for 1 of 1 resident (R1) who was deprived of cardiopulmonary resuscitation (CPR) against the resident's wishes. Findings include: R1's face sheet showed an admission date of 8/21/19, with full code status. R1's Provider Orders for Life Sustaining Treatment (POLST)	21995	Corrected	5/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 3 signed by R1's representative on 8/21/19, indicated R1's wish for staff members to attempt resuscitation/CPR in the event of cardiopulmonary arrest (heart stops). R1's progress notes showed that on 4/2/23, at about 1:20 a.m., licensed practical nurse (LPN)-A assessed R1 having no pulse and no breathing. LPN-A called LPN-B to R1's room, where LPN-B helped nursing assistant (NA)-A to clean up R1. There was a lack of documentation or evidence to show that a staff member started CPR for R1. On 4/18/23, at 1:12 p.m. LPN-B indicated she went to R1's room on 4/2/23, at about 1:30 a.m. and saw that R1 "obviously passed away." LPN-B acknowledged that she did not initiate CPR saying R1 was not under her care. On 4/18/23, at 1:27 p.m., LPN-A stated that on 4/2/23, NA-A called her into R1's room, where she found R1 unresponsive. LPN-A also stated she went out from R1's room to secure stethoscope, call LPN-B, and then went back to assess R1. LPN-A indicated she auscultated for breath sounds but heard nothing, and that R1's legs were splotchy, mottling, cold and stiff when picked up. LPN-B stated she "freaked out" and did not start CPR. During an interview on 4/18/23, at 2:39 p.m., the administrator stated that they (administrator, the social service designee [SSD], and the director of nursing [DON]) were not notified about the incident until the morning of 4/2/23, and that SSD was the one who talked to the staff members thereafter. During an interview on 4/18/23, at 2:39 p.m., the DON stated expectation for staff members to	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 4 provide CPR in a situation like R1's case. The DON added, "I would be surprised if rigor set in that fast." An incident report regarding the failure to provide CPR to R1 was reported to the Minnesota Department of Health on 4/3/23 at 2:58 p.m., more than 37 hours after the incident. The facility's policy titled, Vulnerable Adult Policy and Procedures, with the most recent revision history dated 10/10/22, included in its objectives to protect the health, welfare, and rights of its residents by prohibiting and preventing neglect. The policy directed staff to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately, not later than 2 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 and other officials. The policy directed the DON or SSD to file or contact the designee to file and complete the Minnesota Department of Health Vulnerable Adult online incident report within the required timeframe. SUGGESTED METHOD OF CORRECTION: 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.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00974	A. BUILDING: _____ B. WING _____	C 04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 5 TIME PERIOD FOR CORRECTION: 21 DAYS	21995		