Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

Administrator
Cornerstone Villa
1000 Forest Street
Buhl, MN 55713

RE: CCN: 245612
Cycle Start Date: January 7, 2025

Dear Administrator:

On January 7, 2025, 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)

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On December 20, 2024, the situation of immediate jeopardy to potential health and safety cited at **F689 - Free of Accident Hazards/Supervision/Devices was removed.**

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 listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC) (if not SQC remove this section and note)
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 Villa is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years **effective January 7, 2025.** 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.

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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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)

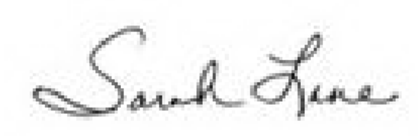
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why 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

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245612	A. BUILDING _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET BUHL, MN 55713

(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 1/3/25 and 1/7/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H56123220C (MN00109257) with deficiencies issued at F689. F689 was issued as an immediate jeopardy at PAST NON-COMPLIANCE H56123660C (MN00109423) Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement. This resulted in an immediate	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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

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F 689	Continued From page 1 jeopardy (IJ) for R1 when she eloped from the facility and was found in the facility parking lot by a passersby. The IJ began on 12/19/24 at 8:44 p.m., when R1 wandered out of the facility. The administrator and director of nursing (DON) were informed of the IJ on 1/7/25 at 3:22 p.m. The facility had implemented corrective action on 12/20/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: R1's Face Sheet dated 3/28/24, indicated R1 had vascular dementia. R1's care plan dated 3/28/24, indicated R1 was at risk for elopement, utilized a WanderGuard system (used to trigger alarms to alert staff when the resident is near an exit door). Interventions included monitor WanderGuard placement on walker every shift, and monitor function. Monitor and document any elopement attempts and wandering. R1's Provider Orders dated 5/15/24, directed to check WanderGuard placement every shift, and check signal strength of the WanderGuard every night. R1's quarterly Minimum Data Set (MDS) dated 10/10/24, indicated R1 had memory problems and severe cognitive impairment skills for daily decision making. The MDS indicated R1 had no wandering or exit seeking behaviors. R1's treatment administration record (TAR) for December, 2024 indicated R1's WanderGuard	F 689		

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F 689	Continued From page 2 was checked on 12/18/24 evening shift and night shift, and on 12/19/24 day shift. The facility Risk Management Report Elopement dated 12/19/24, indicated R1 exited the facility with her walker unattended, and was returned to the facility via a passerby. The report lacked any further information. On 12/19/24 at 9:00 p.m., the temperature in Buhl MN was 12 degrees Fahrenheit (F) with a wind of 10.7 miles per hour per World Weather. The wind chill was 2 degrees F. R1's Elopement Risk Assessment dated 10/10/24 indicated R1 had some intermittent confusion, but no noted wandering. R1 had a purposeful destination in mind when she left her room was not at risk for elopement, but did have a WanderGuard on her walker per her preference. Review of the facility video footage dated 12/19/24 indicated R1 left the building at 8:44 p.m. and returned to the building at 9:02 p.m. R1 was noted to have a red winter coat and shoes on. R1's WanderGuard alarm did not sound as the WanderGuard was never placed on her walker or on her person. On 1/7/25 at 10:04 a.m., registered nurse (RN)-A stated on 12/19/24, during the day shift, she did not "officially" look at R1's walker to ensure the WanderGuard was present. However, she did document in the electronic medical record (EMR) she had checked for placement. It was an "oversight" on her part. On 1/7/25 at 10:13 a.m., licensed practical nurse (LPN)-A stated on 12/18/24, during the night shift,	F 689		

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F 689	Continued From page 3 she didn't check R1's WanderGuard for placement or function. She did not make it to R1's room to check her WanderGuard that night, but she documented she had done it in R1's EMR. She had never checked for function for any resident's WanderGuard until receiving education on 12/20/24 when she was taught to check WanderGuard function. On 1/7/25 at 11:00 a.m., R1's medical doctor (MD)-A stated R1 was not able to make her own decisions and was not safe to leave the facility alone. If R1's WanderGuard was on her, she would have been intercepted before going outside. R1 was incredibly disoriented and would not have known to get back into the facility. She could have gotten hypothermia or been hit by a car as the facility was next to a highway, and even possibly died. On 1/7/25 at 11:40 a.m., the director of nursing (DON) stated staff were expected to check the placement of the WanderGuards every shift, and check the function of the WanderGuards every night. This was not occurring as staff were documenting it completed in the EMR, but were not actually completing the task. On 1/7/25 at 12:02 p.m., LPN-B stated on 12/19/24 around 8:45 p.m., R1 told her she needed to go somewhere. She redirected R1 to her room. About 15 to 20 minutes later, a family member came and got her, and told her R1 was outside. She went outside, and R1 was in a vehicle with a stranger. They stated they were from town, and saw R1 walking close to the road. They stopped and helped her into the car to drove her back to the facility. LPN-B assisted R1 out of the car, and back into the building. R1's	F 689		

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F 689	Continued From page 4 WanderGuard alarm didn't sound, and then noticed R1 did not have a WanderGuard on. On 12/18/24 during the evening shift, she didn't check placement of R1's WanderGuard because she thought it had alarmed when R1 entered the double doors after an activity. The WanderGuard manufacture's manual directed to test WanderGuard signaling devices daily and record the results in the resident's records. The past non-compliance immediate jeopardy began on 12/19/24. The IJ was removed, and the deficient practice was corrected by 12/20/24, after the facility implemented a systemic plan that included the following actions: Reviewed their policies on use of WanderGuards, re-assessed all residents who were at risk for elopement to ensure they had a WanderGuard in place and in working order, and re-educated all nursing staff on the expectation of WanderGuard function and monitoring policies. The facility completed daily audits to ensure compliance, and will bring the results of the audits to the Quality Assurance and Performance Improvement (QAPI) committee. Verification of corrective action was confirmed by observation, interview, and document review on 1/7/25.	F 689		

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January 17, 2025

Administrator
Cornerstone Villa
1000 Forest Street
Buhl, MN 55713

Re: Event ID: S00211

Dear Administrator:

The above facility survey was completed on January 7, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23242	A. BUILDING: _____ B. WING _____	C 01/07/2025

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CORNERSTONE VILLA	1000 FOREST STREET BUHL, MN 55713

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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 1/3/25 and 1/7/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H56123220C (MN00109257) H56123660C (MN00109423) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		