Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: HL303602781M
Compliance: HL303601115C

Date Concluded: July 30, 2026

Name, Address, and County of Licensee Investigated:
Cornerstone Residence of Fosston
115 1st Street East
Fosston, MN 56542
Polk County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation: The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s): The facility neglected the resident when the resident fell multiple times over a 24-hour period and was sent to the hospital. The resident was found to have to be unkempt with dried feces on his skin and clothing when he arrived at the hospital. The resident had had several areas covered in dried feces and multiple areas of skin breakdown.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident had four falls in a 16-hour period of time, the facility transferred the resident to the emergency room where it was found he was septic from an infection. Regarding dried feces, the emergency room records did not corroborate this allegation. The investigation did identify a staffing concern, which was addressed with a correction order (see Action taken by the Minnesota Department of Health below).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the primary

care provider. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's room.

The resident resided in an assisted living facility. The resident's diagnoses included history of stroke with right- sided hemiparesis and aphasia (a language disorder that affects how you communicate resulting in difficulty speaking, understanding, reading, and writing.) The resident's assessment indicated the resident had right-sided paralysis due to a past stroke. The resident's service plan included weekly assistance with bathing, a weekly skin check, daily assistance with dressing, and assistance with toileting/incontinence cares as needed. The resident was unable to walk, transferred by stand-and-pivot while using a wheelchair for mobility.

Falls

A concern arose when the resident had four falls over the course of about 16 hours and was transferred to the emergency room. Additionally, when the resident arrived in the emergency room, he was unkempt and had areas of dried stool on his skin and clothing.

The resident's medical record at the facility indicated he was at risk for falls however his most recent fall was documented six months prior to this event. The service plan did not include any interventions specifically addressing falls.

The progress notes indicated the resident fell four times over a 16-hour period. His vital signs were checked with each fall which showed his blood pressure and respirations were fluctuating.

- 3 AM while transferring from wheelchair to chair in his room with a blood pressure of 119/70 with respirations 20
- 4 PM when he slipped out of his chair in his room with a blood pressure of 65/46 with respirations 32
- 5:10 PM when he slipped out of his chair with a blood pressure of 112/64 with respirations 30
- 8:00 PM when he fell from his wheelchair while transferring onto the toilet with a blood pressure of 80/54 with respirations 32

The same document indicated the nurse was called with each fall. After the fourth fall, the facility called 911 and transferred the resident to the emergency room.

Hospital records indicated the resident was diagnosed with septic shock from an unknown source, an acute kidney injury, and two fractured ribs from his recent falls. The resident was transferred to the intensive care unit (ICU).

A review of the emergency room records did not identify documentation to corroborate the resident had dried stool on his skin or clothing.

Skin Concern
An assessment completed by the facility nurse approximately one week prior to the resident's hospitalization indicated the resident did not have any skin concerns.

However, when the resident was sent to the emergency room the hospital staff consulted wound care after an area of non-blanchable redness was observed on the resident's buttocks and hip area. (Non-blanchable redness is categorized as a stage 1 pressure ulcer although the skin remains intact).

An image from the hospital records showed a large red area across the resident's buttocks. Hospital records indicated dressing to the resident's sacrum and right hip was implemented to protect the area.

The resident was discharged to a rehab facility after his hospitalization and returned to the facility about a month later. Upon the resident's return, the facility nurse completed an assessment and again documented the resident did not have any current skin concerns. Three days after the assessment was completed, facility staff documented the resident had a dressing to his right buttocks which was falling off. Staff tried putting on new dressing, but that also fell off. Unlicensed staff wrote they were applying a barrier ointment to "both the sore on his right butt cheek as well as the skin in the crack of his butt due to the skin appearing to have broken down/opening."

During an interview, the licensed assisted living director stated she asked staff if the resident had any wounds and staff reported he currently had two small sores on his buttocks. The licensed assisted living director confirmed this was not noted in any of his nursing assessments or nursing documentation.

During an interview, the facility nurse stated regarding the resident's blood pressures the day of the four falls she told staff to recheck the resident's blood pressure in 40 to 45 minutes and to push fluids and tomato juice to bring it back up and by the time staff went back to re-check it, the resident fell again. Regarding the resident's skin the nurse stated the unlicensed staff completed skin checks and if any concerns were noted, they would be reported to her. The facility nurse stated she was not aware the resident had skin concerns before and after his hospitalization or rehab stay. However, she was aware the resident had a dressing on his buttocks upon his return to the facility but all they saw was a red area and staff were applying a barrier cream.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Unable due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: No action taken.

Action taken by the Minnesota Department of Health: The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30360	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE FOSSTON	115 1ST STREET EAST FOSSTON, MN 56542

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL303602781M/ #HL303601115C On April 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL303602781M/ #HL303601115C, correction order identification 0470..	0 000		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	0 470		

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0 470	Continued From page 1 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure sufficient staffing to meet the needs of three of three residents (R1, R2, R3) who required a two-person assist after falling. R1 had three falls which required emergency medical services (EMS) to respond to the facility to provide lift assistance as only one staff member was working and able to respond. R2 and R3 also had falls which required EMS response to get them off the floor. In addition, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included	0 470		

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0 470	Continued From page 2 reviewing the staffing plan at least twice per year. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 lived on the assited living side of the facility. R1's assessment indicated he had right sided paralysis and was at risk for falls. R1 fell on March 24, 2026, at 3:00 a.m. R1's incident report indicated the registered nurse (RN) was notified and staff were directed to call EMS for help to get the resident off the floor. R1 fell on March 24, 2026, at 5:10 p.m. R1's incident report indicated the RN was notified and staff were directed to call EMS for help to get resident off the floor. R1 fell on March 24, 2026, at 8:00 p.m. R1's incident report indicated the RN was notified and staff were directed to call EMS for help to get resident off the floor. R1 was later taken to the emergency room. R2 R2 lived on the assisted living side of the facility. R2 fell on April 2, 2026, at 9:00 p.m. R2's incident report indicated the RN was notified and 911 was called for help to get the resident off the floor.	0 470		

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0 470	Continued From page 3 R3 R3 lived on the assisted living side of the facility. R3 fell on April 25, 2026, at 1:35 p.m. R3's incident report indicated the RN was notified and 911 was called for help to get the resident off the floor. Interviews On April 27, 2026, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated on overnight shifts, there was only one unlicensed personnel (ULP) working on the assisted living side and the memory care ULP was not able to leave the unit unsupervised so they would not be able to respond to any two-person assist needs on the assisted living side. CNS-B stated staff would have to call the non-emergency line and request emergency medical services (EMS) to come to provide lift assistance. CNS-B stated EMS would often be irritated with the facility for being called to provide lift assists. CNS-B stated requests to EMS would be in streaks depending on falls but said it was only a couple of times a month they were called to provide lift assistance. On April 29, 2026, at 9:15 a.m., unlicensed personnel (ULP)-C stated when she worked overnights on the assisted living side, memory care staff would not be able to come assist them. ULP-C stated if she had issues with transferring a resident after a fall, she would contact the RN, and the RN would direct her to call 911. ULP-C stated emergency medical services would then respond and help get the resident off the floor. On April 29, 2026, at 10:20 a.m., R1's case manager (CM)-D stated R1's Medicaid had been	0 470		

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0 470	Continued From page 4 billed by the ambulance for providing a lift assist after a fall. On April 29, 2026, at 11:05 a.m., licensed assisted living director (LALD)-A stated she had asked about a staffing plan but in the four months she had worked at the facility, she had not seen or been able to review the licensee's staffing plan. LALD-A stated since there was only one ULP on the assisted living side at night, if they needed help with a transfer they would have to call 911 for lift assistance. LALD-A stated she was not aware residents were then billed for this service. On April 30, 2026, at CNS-B stated she was not previously aware residents were billed for lift assists provided by EMS when the facility was not able to provide an assist of two. The licensee's Staffing & Scheduling policy dated August 1, 2021, and reviewed on May 14, 2025, indicated the clinical nurse supervisor would develop and implement a written staffing plan providing an adequate number of qualified direct-care staff to meet resident needs 24 hours per day, 7 days per week. The same document indicated the staffing plan and schedule to be evaluated by the clinical nurse supervisor at least twice per year to ensure appropriate staffing levels in the facility. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated October 17, 2025, indicated three unlicensed personnel (ULP) worked on the day and evening shift and two ULP worked on the overnight shift. One ULP was in the secured memory care unit and the other ULP was on the assisted living side. Transfers with an assist of two staff were only available in the secured memory care unit side.	0 470		

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0 470	Continued From page 5 The licensee's written staffing plan was requested, however the licensee did not provide one. Minnesota Administrative Rule 4659.0180 Subp. 5, indicated direct-care staff availability included a minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		