

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Cornerstone Villa			Report Number: H5612009	Date of Visit: May 31, 2016 and — June 1, 2016
Facility Address: 1000 Forest Street			Time of Visit: 1:00 p.m. to 4:00 p.m.	Date Concluded: December 21, 2016
Facility City: Buhl			9:30 a.m. to 4:30 p.m. Investigator's Name and	 Title:
State: Minnesota	ZIP: 55713	County: Saint Louis	Carol Bode, RN	

Nursing Home

Allegation(s):

It is alleged that a resident was neglect when facility staff failed to follow the resident's care plan, and s/he had a fall resulting in facial fractures. The resident passed away two days later.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ▼ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility failed to provide assistance with ambulation when the resident's assessment and care plan indicated the resident required assistance when ambulating and the resident fell and sustained facial fractures.

The resident's diagnoses included Alzheimer's, sensory difficulty, and generalized weakness. The resident was capable of making his/her basic needs known to staff, but required the assistance of others for decision-making. The resident required staff hands on assistance during ambulation.

The resident was admitted to the facility in the early evening. The admitting nurse assessed the resident and determined the resident was weak and was not safe to ambulate independently. The care plan indicated ambulation only with assistance from staff. The physical therapist evaluated the resident the next day and determined the resident was unsteady when ambulating and needed contact guard assist which means a staff person must have a hand on resident at all times to prevent falls. The care plan indicated the need to assist the resident when transferring and ambulating. Later that evening, five staff observed the resident ambulating independently with the walker on his/her unit and another adjoining unit, but staff did not intervene. Staff heard the after hours front door alarm, went to the door, and found the resident outside lying on the cement in the doorway. Staff who found the resident called for a nurse. The nurse provided the resident with medical care to control the bleeding and another nurse called for an ambulance.

Facility Name: Corr	nerstone Villa	Report Number: H5612009
The resident had su evaluation and cons	istained multiple facial fracture	Il hospital had to transfer the resident to a trauma center. es, requiring intubation to maintain a patent airway. After 's facial fractures, conservative care was chosen for o days later.
The resident's deat fall.	h certificate indicated the caus	se of death was complications from facial fractures after a
Minnesota Vulnerab	ole Adults Act (MN 626.557)	
Under the Minnesot	a Vulnerable Adults Act (MN.	626.557):
☐ Abuse	Neglect Neglect	Financial Exploitation
Substantiated ■	☐ Not Substantiated	☐ Inconclusive based on the following information:
determined that the Abuse The facility had a possistance to preventherapists assessed	☐ Individual(s) and/or ☐ Fa☐ Neglect ☐ Financial Expolicy in place that directed staffact falls. All residents new to the that the resident required conthe resident needed assistance.	etion 626.557, subdivision 9c (c) were considered and it was acility is responsible for the ploitation. This determination was based on the following: If to provide each resident with adequate supervision and ne facility required close monitoring. The physical ntact guard assistance when ambulating and the resident's e with ambulation. Multiple staff allowed the resident to
substantiated against possible inclusion of	t an identified employee, this re f the finding on the abuse regis	to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services provisions of the background study requirements under
Compliance:		
The facility was four		utes, section 626.557) – Compliance Met ate Statutes for Vulnerable Adults Act (MN Statutes, sued.
		42 CFR, Part 483, subpart B) - Compliance Not Met or Long Term Care Facilities (42 CFR, Part 483, subpart B),
Deficiencies are issu	ed on form 2567: 🗵 Yes	□ No
(The 2567 will be av	ailable on the MDH website.)	
		s Chapter 4658) - Compliance Not Met Nursing Homes (MN Rules Chapter 4658) were not met

Facility Name: Cornerstone Villa	Report Number: H5612009
State licensing orders were issued: Yes No	
(State licensing orders will be available on the MDH website.)	
State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 & 144A were not met.	
State licensing orders were issued: 🗵 Yes 🗌 No	
(State licensing orders will be available on the MDH website.)	
Compliance Notes:	
Facility Corrective Action: The facility took the following corrective action(s):	
The facility reviewed and updated their policy and procedures for care plans and fall educated on the changes as well as communication with the therapy department. A conducted to evaluate the non-compliance with regulations. The facility was found b September 2016.	follow-up visit was
Definitions:	
Minnesota Statutes, section 626.5572, subdivision 17 - Neglect "Neglect" means:	

- (a) 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.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Facility Name: Cornerstone Villa Report Number: H5612009

<u>Document Review</u>: The following records were reviewed during the investigation:

Other pertinent medical records:
Additional facility records:
■ Resident/Family Council Minutes
Facility Internal Investigation Reports
▼ Facility In-service Records
Facility Policies and Procedures
Number of additional resident(s) reviewed: 3
Were residents selected based on the allegation(s)?
Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?
○ Yes ○ No ○ N/A Specify:
Interviews: The following interviews were conducted during the investigation: Interview with complainant(s)
If unable to contact complainant, attempts were made on:
Date: Time: Date: Time: Date: Time:
Interview with family: Yes No N/A Specify: Did you interview the resident(s) identified in allegation: Yes No N/A Specify:
Did you interview additional residents? Yes No
Total number of resident interviews:2
Interview with staff: Yes No N/A Specify:
Tennessen Warnings Tennessen Warning given as required:
Physician Interviewed: Yes No
Nurse Practitioner Interviewed: Yes No
Physician Assistant Interviewed: (Yes (No
Interview with Alleged Perpetrator(s): Yes No N/A Specify:

Fac	cility Name: Co	ornerstone Villa				Report Number: H5612009
Att	empts to conta	act:				
Dat	te:	Time:	Date:	Time:	Date:	Time:
		•	issued: O Yes, d	ate subpoena was	s issued	
		ade with any of tersonnel 🔲 P	olice Officers 🗵	Medical Examine	r 🗌 Other:	Specify
X X X X Wa	Personal Car Nursing Serv Dignity/Priva Safety Issues Facility Tour s any involved s equipment b	ices icy Issues	ected: () Yes () safe manner: ()	○ No	N/A	
	_		nsing & Certification or Nursing Home A			
		budsman for Lo	_			
	hl Police Depa		ng rerm cure			
	nt Louis Count					
	hl City Attorne	•				
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PRINTED: 08/25/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245612	B. WING				C 23/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 000 FOREST STREET PO BOX 724 BUHL, MN 55713	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F (000			
F 323 SS=G	to investigate case following deficiency The facility is enroll signature is not req page of the CMS-2s submission of the F verification of comp 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	ed in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as diance.	F3	323			
	by: Based on interview facility failed to ensist staff did not implem plan developed to nof 3 residents (R1) failure resulted in acleading to death) for Findings include: R1's medical record diagnosis list from a indicated R1 had a	NT is not met as evidenced and document review, the ure a safe environment when the individualized care ninimize the risk for falls for 1 reviewed for falls. The facility's ctual harm (facial fractures r R1. If was reviewed. R1's admission on 05/04/2016, history of alzheimer/dementia, and wheezing, recurrent					
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITI F		(X6) DATE

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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245612	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713	08/23/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	urinary track infecti and hypertension. ⁻ 05/04/2016 indicate person, but not place	ons, congestive heart failure, The nursing assessment dated ed R1 was orientated to	F 323			
	indicated R1 neede and repositioning. F assessed for elope hours. R1 did not h	ed supervision for transferring R1 was in the process of being ment risk which takes 72 ave a personal alarm.				
	was completed on a required contact gut times. CGA was de to the resident at al	ical therapy (PT) assessment 5/5/2016 which indicated R1 ard assist (CGA) by staff at all fined by PT as staff holding on I times while ambulating with a bit to be ambulating alone.				
	R1's needs for assi	n dated 05/05/2016, identified stance with ambulation, sitioning as well as weakness pairments.				
	Report form dated revealed nursing as body lying on the coof the building. Licralso responded to twas the second to adown on the sidewapresent. Registere after and started ar called an ambulance indicated R1 had be with her walker, by any door she could	•				
	The fall incident rep	oort dated 05/05/2016,				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245612	B. WING	i	U160 40 MARIANIA	1	23/2016
	PROVIDER OR SUPPLIER	<u> </u>		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713		
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F 323	indicated R1 was a A facility investigatii indicated at 8:40 p. area. At 8:43 p.m. tamarack nurses dand ambulated to the facility. The front dinvestigation by stafront door on the simust have gotten the door way. R1 was transferred to a large Due to the extent of on comfort cares a Hospital record from a standing posmultiple facial fraction intubate the residen R1 was transferred evaluation and due the family chose conditions are complications secondary to a fall. Buring an interview the administrator strong an interview director of nurses in the side of the side	mbulating just prior to the fall. ve report dated 05/09/2016, m. R1 was in the common R1 walked with her walker to esk. At 8:46 p.m. R1 leaves he front entry area of the loor alarm went off and upon off, R1 was found outside the dewalk. The report stated R1 he walker entangled in the ladmitted to one hospital and ger hospital the same night. If the injuries, R1 was placed and died at the hospital. Med 05/05/2016 was reviewed a indicated the resident fell sition. The resident received ure, the hospital needed to not to maintain a patent airway. It to a larger hospital for to the severity of the injuries, omfort care. R1 died at the of cranial facial fractures May 1.00 p.m. tated she had watched the from the night R1 fell. R1	F	323			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMPLETED		
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F 323	During an interview RN-F indicated R1 around by herself hassessed yet. She ambulate alone an not where she was time. During an interview social services (SS admission for R1. 5/5/2016, recomme R1 should not have SS-E conducted the fall and stated LPN walking by herself from one unit to the only orientated to was an aid there was not wheelchair because the risk of elopeme front door alarm are found R1 on the great the risk of elopeme front door alarm are found R1 on	on 5/31/2016 at 3:40 p.m., should not have been walking because she had not been as aid R1 was too unsteady to d R1 only knew who she was, and did not have a concept of w on 06/01/2016 at 10:30 a.m. and did not have a concept of the said PT evaluated R1 on ending CGA only. SS-E said to been walking by herself. The investigation following R1's are investigation following R1's and RN-C indicated R1 was before the fall. R1 was walking the next unit. SS-E said R1 was who she was. To 00/01/2016, at 12:05 p.m. NA)-A stated a staff person inbulating independently. NA-A a wanderguard or alarm on the se R1 was being assessed for ent. NA-A said she heard the not when she got there and she round outside the facility. NA-A is off to the left side and it had lost her balance. To 06/01/2016, at 12:30 p.m. (PT)-D indicated she evaluated CGA at all times. PT-D stated to been ambulating		323				
	Licensed Practical	v on 6/1/2016 at 12:55 p.m. Nurse (LPN)-B stated after the saw R1 walking around the						

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		245612	B. WING			l	23/2016
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 000 FOREST STREET PO BOX [.] 724 BUHL, MN 55713	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R1 was walking on said R1 looked like people, but appears walking around. LF assessed by PT and direction. She said standby assist. LP anyone to ambulate walking well by hersthink R1 was in any On 06/01/2016, at 2 and investigator resurveillance. The varound the building supervision or CGA it looked like she taturned around and the building. R1 pudouble doors and wpush button to autopushed the door opsecond set of doub open herself and fedoor. The video do R1 fell, only of R1 fby staff in front of the An undated facilitie indicated a fall risk completed at the tire Each resident woul supervision and assistance.	using a walker. She also said another unit as well. LPN-B she was looking at other ed not to have a purpose while PN-B indicated residents were d the nurses follow PT's PT instructed staff to give R1 N-B said she did not send e with R1 because R1 was self. LPN-B said she didn't danger. 2:55 p.m. the administrator view the facility video independently without staff at R1 walked through two units, lked to another resident, went into the reception area of ished opened right door of the valked out. R1 did not use the matically open the door, R1 ben herself. R1 went to the le doors, pushed the right door all while going through the bes not show the details of how alling. The walker was found the left side of the two doors. Is fall policy and procedure assessment would be the of admission to the facility directive adequate sistance to prevent resident ents new to the facility must	F	323			

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ С B. WING _ 08/23/2016 23242 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 **CORNERSTONE VILLA** BUHL, MN 55713 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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:** A complaint investigation was conducted to investigate complaint #H5612009. As a result the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Compliance Monitoring, Office of

TITLE

(X6) DATE

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIDEN.	A. BUILDING:		1 _	
		23242	B. WING		08/2	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	RSTONE VILLA			T PO BOX 724		
- COTTIVE	COTONE VILLA	BUHL, MI	N 55713			ı
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2 000	Continued From pa	ge 1	2 000			
	Health Facility Com Place, Suite 220, S 55164-0970.	nplaints; 85 East Seventh t. Paul, Minnesota,				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident				
	by: Based on interview facility failed to ens staff did not implem plan developed to r of 3 residents (R1)	ent is not met as evidenced and document review, the ure a safe environment when nent the individualized care minimize the risk for falls for 1 reviewed for falls. The facility's ctual harm (facial fractures or R1.				
	Findings include:					
	diagnosis list from indicated R1 had a shortness of breath	d was reviewed. R1's admission on 05/04/2016, history of alzheimer/dementia, and wheezing, recurrent ons, congestive heart failure				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. SUING	STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER CORNERSTONE VILLA STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 BUHL, MN 55713 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	AND FLAN OF CORRECTION
CORNERSTONE VILLA 1000 FOREST STREET PO BOX 724 BUHL, MN 55713 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1000 FOREST STREET PO BOX 724 BUHL, MN 55713 ID PREFIX TAG (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATE	
CORNERSTONE VILLA BUHL, MN 55713 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BUHL, MN 55713 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLE DATE	NAME OF PROVIDER OR SUP
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CORNERSTONE VILLA
	PREFIX (EACH DEFI
and hypertension. The nursing assessment dated 05/04/2016 indicated R1 was orientated to person, but not place or time. The nursing assessment dated 5/04/2016, indicated R1 needed supervision for transferring and repositioning. R1 was in the process of being assessed for elopement risk which takes 72 hours. R1 did not have a personal alarm. An admission physical therapy (PT) assessment was completed on 5/5/2016 which indicated R1 required contact guard assist (CGA) by staff at all times. CGA was defined by PT as staff holding on to the resident at all times while ambulating with a walker. R1 was not to be ambulating alone. The initial care plan dated 05/05/2016, identified R1's needs for assistance with ambulation, transfers, and repositioning as well as weakness causing mobility impairments. Review of the facility's Resident/Accident/Incident Report form dated 5/5/2016, at 8.45 p.m. revealed nursing assistant (NA)-A observed R1's body lying on the cement outside of the front door of the building. Licensed Practical Nurse (LPN)-B also responded to the after hours door alarn and was the second to arrive. R1 was lying face down on the sidewalk, moaning with a lot of blood present. Registered Nurse (RN)-C arrived shortly after and started an assessment while LPN-B called an ambulance. In the report, LPN-B indicated R1 had been walking around the facility with her walker, by herself, attempting to get out any door she could open. The fall incident report dated 05/05/2016, indicated R1 was ambulating just prior to the fall. A facility investigative report dated 05/09/2016,	and hypertens 05/04/2016 incomperson, but not the nursing a indicated R1 rand reposition assessed for a hours. R1 did An admission was complete required contatimes. CGA without the resident walker. R1 with a revealed nurse body lying on of the building also responded was the second down on the second down on the second and start called an ambindicated R1 with her walked any door she of the fall incided indicated R1 with a revealed responded to the second down on the second down down down down down down down d

Minnesota Department of Health

STATEMEN	TO DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		С	
	23242		B. WING		1	, 3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	STONE VILLA	1000 FOR BUHL, MN		T PO BOX 724		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	indicated at 8:40 p. area. At 8:43 p.m. tamarack nurses de and ambulated to the facility. The front description by state front door on the sign must have gotten the door way. R1 was transferred to a large Due to the extent of on comfort cares and the hospital record from a standing posmultiple facial fraction intubate the resider R1 was transferred evaluation and due the family chose conditions are complications secondary to a fall. During an interview the administrator significant was complications secondary to a fall. During an interview director of nurses in the significant was complications.	m. R1 was in the common R1 walked with her walker to esk. At 8:46 p.m. R1 leaves he front entry area of the oor alarm went off and upon ff, R1 was found outside the dewalk. The report stated R1 he walker entangled in the admitted to one hospital and ger hospital the same night. If the injuries, R1 was placed and died at the hospital. ed 05/05/2016 was reviewed a indicated the resident fell esition. The resident received ure, the hospital needed to not to maintain a patent airway. To a larger hospital for to the severity of the injuries, emfort care. R1 died at the of cranial facial fractures on 5/31/2016, at 1:10 p.m. tated she had watched the from the night R1 fell. R1	2 830	DETICIENCY		
	RN-F indicated R1	on 5/31/2016 at 3:40 p.m., should not have been walking because she had not been				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
23242			B. WING		C 08/23/2016		
	PROVIDER OR SUPPLIER		EST STREE	STATE, ZIP CODE T PO BOX 724			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION FICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)					
2 830	ambulate alone and not where she was time. During an interview social services (SS admission for R1. S 5/5/2016, recomme R1 should not have SS-E conducted the fall and stated LPN walking by herself the from one unit to the only orientated to w During an interview nursing assistant (N told her R1 was am said there was not a wheelchair because the risk of elopeme front door alarm and found R1 on the grosaid the walker was appeared like R1 had During an interview Physical therapist (R1 who needed a CR1 should not have independently. During an interview Licensed Practical evening meal, she sunit independently R1 was walking on	said R1 was too unsteady to d R1 only knew who she was, and did not have a concept of on 06/01/2016 at 10:30 a.m. on 06/01/2016 at 10:30 a.m. on the said PT evaluated R1 on anding CGA only. SS-E said been walking by herself. The investigation following R1's on the Band RN-C indicated R1 was before the fall. R1 was walking a next unit. SS-E said R1 was who she was. On 06/01/2016, at 12:05 p.m. who she was. On 06/01/2016, at 12:05 p.m. who she was being assessed for a wanderguard or alarm on the extra R1 was being assessed for nt. NA-A said she heard the dwhen she got there and she bound outside the facility. NA-A off to the left side and it and lost her balance. On 6/01/2016, at 12:30 p.m. PT)-D indicated she evaluated CGA at all times. PT-D stated	2 830				
1	people, but appeare	ed not to have a purpose while					

Minnesota Department of Health

PRINTED: 08/25/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN OF COUNTE	,110N	IDENTIFICATION NOMBER.	A. BUILDING:		C		
		23242	B. WING			, 3/2016	
NAME OF PROVIDER O	R SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE			
CORNERSTONE V	ILLA			T PO BOX 724			
2.0.12	LIMMANDV CT/	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX (EACH	H DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
2 830 Continue	d From pa	ige 5	2 830				
walking a assessed direction standby anyone to walking a think R1. On 06/0 and investing around the supervision of the build double double double double double double double double door. The R1 fell, of by staff in the build double door. The R1 fell, of by staff in the supervision of the supervision falls. An have clooped to supervision falls. An have clooped the direction of the direction of the direction of the direction of the supervision of the direction o	around. Lid by PT and She said assist. LP of ambulate well by her was in any 1/2016, at stigator revoce. The vone building ion or CGA like she taround and ing. R1 puroors and votes of doubt self and feel a fall risk and at the till is ident would in and as d, all reside to end on the control of the contro	PN-B indicated residents were d the nurses follow PT's PT instructed staff to give R1 N-B said she did not send with R1 because R1 was self. LPN-B said she didn't danger. 2:55 p.m. the administrator wiew the facility video video showed R1 walked independently without staff A. R1 walked through two units, went into the reception area of ushed opened right door of the valked out. R1 did not use the matically open the door, R1 on herself. R1 went to the led doors, pushed the right door will while going through the less not show the details of how falling. The walker was found the left side of the two doors. It fall policy and procedure assessment would be the of admission to the facility. It receive adequate sistance to prevent resident ents new to the facility must	2 830				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	22242		B. WING			2/2016
		23242			00/2	23/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE T PO BOX 724		
CORNER	RSTONE VILLA	BUHL, MN		1 PO BOX 724		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21850	MN St. Statute 144 Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850		·	
	Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non-physical pain or injuconduct intended to distress. Every resnon-therapeutic che except in fully docu authorized in writing resident's physiciar period of time, and	om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the -therapeutic infliction of ary, or any persistent course of o produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as g after examination by a n for a specified and limited only when necessary to the from self-injury or injury to				
	by: Based on interview facility failed to ens maltreatment when individualized care the risk for falls for for falls. The facility	and document review, the ure a resident was free from staff did not implement the plan developed to minimize 1 of 3 residents (R1) reviewed 's failure resulted in actual es leading to death) for R1.				
	Findings include:					
	diagnosis list from a indicated R1 had a	d was reviewed. R1's admission on 05/04/2016, history of alzheimer/dementia, a and wheezing, recurrent				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
23242		23242	B. WING			, 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	STONE VILLA			T PO BOX 724		
BUHL, M				PROVIDEDIO DI ANI OF CORDECTI	ON	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	Continued From pa	ige 7	21850			
	urinary track infecti and hypertension.	ons, congestive heart failure, The nursing assessment dated ed R1 was orientated to				
	indicated R1 neede and repositioning. F assessed for elope	sment dated 5/04/2016, ed supervision for transferring R1 was in the process of being ment risk which takes 72 ave a personal alarm.				
	was completed on a required contact gut times. CGA was de to the resident at al	ical therapy (PT) assessment 5/5/2016 which indicated R1 lard assist (CGA) by staff at all fined by PT as staff holding on I times while ambulating with a bt to be ambulating alone.				
	R1's needs for assi	n dated 05/05/2016, identified stance with ambulation, sitioning as well as weakness pairments.			,	
	Report form dated revealed nursing as body lying on the coof the building. Licalso responded to twas the second to down on the sidewapresent. Registere after and started ar called an ambulancindicated R1 had be with her walker, by any door she could	•				
		port dated 05/05/2016, mbulating just prior to the fall.				

Minnesota Department of Health

PRINTED: 08/25/2016 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 08/23/2016 23242 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1000 FOREST STREET PO BOX 724 **CORNERSTONE VILLA** BUHL, MN 55713 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 8 21850 A facility investigative report dated 05/09/2016, indicated at 8:40 p.m. R1 was in the common area. At 8:43 p.m. R1 walked with her walker to tamarack nurses desk. At 8:46 p.m. R1 leaves and ambulated to the front entry area of the facility. The front door alarm went off and upon investigation by staff, R1 was found outside the front door on the sidewalk. The report stated R1 must have gotten the walker entangled in the door way. R1 was admitted to one hospital and transferred to a larger hospital the same night. Due to the extent of the injuries, R1 was placed on comfort cares and died at the hospital. Hospital record dated 05/05/2016 was reviewed The hospital record indicated the resident fell from a standing position. The resident received multiple facial fracture, the hospital needed to intubate the resident to maintain a patent airway. R1 was transferred to a larger hospital for evaluation and due to the severity of the injuries, the family chose comfort care. R1 died at the hospital. R1's death certificate indicated cause of death was complications of cranial facial fractures secondary to a fall. During an interview on 5/31/2016, at 1:10 p.m. the administrator stated she had watched the video surveillance from the night R1 fell. R1 went out the front door and she fell.

by herself.

During an interview on 5/31/2016, at 3:30 p.m. director of nurses indicated after the investigation was completed. R1 should not have been walking

During an interview on 5/31/2016 at 3:40 p.m., RN-F indicated R1 should not have been walking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		C	
		23242	B. WING			3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CORNER	RSTONE VILLA			T PO BOX 724		
BUHL, M				PROVIDER'S PLAN OF CORRECTI)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	Continued From pa	ige 9	21850			
	assessed yet. She ambulate alone and	ecause she had not been said R1 was too unsteady to d R1 only knew who she was, and did not have a concept of				
	social services (SS admission for R1. 5/5/2016, recomme R1 should not have SS-E conducted the fall and stated LPN walking by herself by	on 06/01/2016 at 10:30 a.m.)-E indicated she did the She said PT evaluated R1 on ending CGA only. SS-E said been walking by herself. e investigation following R1's -B and RN-C indicated R1 was before the fall. R1 was walking e next unit. SS-E said R1 was who she was.				
	nursing assistant (Noted her R1 was am said there was not wheelchair because the risk of elopeme front door alarm an found R1 on the great the walker was	on 06/01/2016, at 12:05 p.m. NA)-A stated a staff person abulating independently. NA-A a wanderguard or alarm on the R1 was being assessed for nt. NA-A said she heard the d when she got there and she bund outside the facility. NA-A soff to the left side and it ad lost her balance.				
	Physical therapist (on 6/01/2016, at 12:30 p.m. PT)-D indicated she evaluated CGA at all times. PT-D stated been ambulating				
	Licensed Practical evening meal, she unit independently R1 was walking on	on 6/1/2016 at 12:55 p.m. Nurse (LPN)-B stated after the saw R1 walking around the using a walker. She also said another unit as well. LPN-B she was looking at other				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

CORNERSTONE VILLA

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

B. WING

1000 FOREST STREET ADDRESS, CITY, STATE, ZIP CODE

1000 FOREST STREET PO BOX 724

BUHL, MN 55713

(X4) ID

PROVIDER'S PLAN OF CORRECTION

(X5) COMPLETED

COMPLETED

(X6) DEPOSITE OF CORRECTION SHOULD BE COMPLETED

(X6) DEPOSITE OF CORRECTION SHOULD BE COMPLETED

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SUMMARY STATEMENT OF DEFICIENCIES (RECHOLDERFICENCY WISSTEE REFECED BY PILL (RECHOLDERFICENCY WISSTEE REFECED BY VILL (RECHOLDERFICENCY) 21850 Continued From page 10 people, but appeared not to have a purpose while walking around. LPN-B indicated residents were assessed by PT and the nurses follow PT's direction. She said PT instructed staff to give R1 standby assist. LPN-B said she edidn't think R1 was in any danger. On 06/01/2016, at 2:55 pm. the administrator and investigator review the facility video surveillance. The video showed R1 walked around the building independently without staff supervision or CGA. R1 walked through two units, it looked like she talked to another resident, turned around and went into the reception area of the building. R1 pushed opened right door of the double doors and walked out. R1 did not use the push button to automatically open the door; R1 pushed the door open herself. R1 went to the second set of double doors, pushed the right door open herself and fell while going through the door. The video does not show the details of how R1 fell, only of R1 falling. The walker was found by staff in front of the left side of the two doors. An undated facilities fall policy and procedure indicated a fall risk assessment would be completed at the time of admission to the facility. Each resident would receive adequate supervision and assistance to prevent resident falls. And, all residents new to the facility have close monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure resident care plans are followed. The DON of designee could then perform auditist to ensure compliance to resident are relates.	CORNERSTONE VILLA BUHL, MN 55713						
people, but appeared not to have a purpose while walking around. LPN-B indicated residents were assessed by PT and the nurses follow PT's direction. She said PT instructed staff to give R1 standby assist. LPN-B said she did not send anyone to ambulate with R1 because R1 was walking well by herself. LPN-B said she didn't think R1 was in any danger. On 06/01/2016, at 2:55 p.m. the administrator and investigator review the facility video surveillance. The video showed R1 walked around the building independently without staff supervision or CGA. R1 walked through two units, it looked like she talked to another resident, turned around and went into the reception area of the building. R1 pushed opened right door of the double doors and walked out. R1 did not use the push button to automatically open the door, R1 pushed the door open herself. R1 went to the second set of double doors, pushed the right door open herself and fell while going through the door. The video does not show the details of how R1 fell, only of R1 falling. The walker was found by staff in front of the left side of the two doors. An undated facilities fall policy and procedure indicated a fall risk assessment would be completed at the time of admission to the facility. Each resident would receive adequate supervision and assistance to prevent resident falls. And, all residents new to the facility must have close monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure resident care plans are followed. The DON or designee could then perform audits to ensure complicance to resident	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE		
		people, but appeared not to have a purpose while walking around. LPN-B indicated residents were assessed by PT and the nurses follow PT's direction. She said PT instructed staff to give R1 standby assist. LPN-B said she did not send anyone to ambulate with R1 because R1 was walking well by herself. LPN-B said she didn't think R1 was in any danger. On 06/01/2016, at 2:55 p.m. the administrator and investigator review the facility video surveillance. The video showed R1 walked around the building independently without staff supervision or CGA. R1 walked through two units, it looked like she talked to another resident, turned around and went into the reception area of the building. R1 pushed opened right door of the double doors and walked out. R1 did not use the push button to automatically open the door, R1 pushed the door open herself. R1 went to the second set of double doors, pushed the right door open herself and fell while going through the door. The video does not show the details of how R1 fell, only of R1 falling. The walker was found by staff in front of the left side of the two doors. An undated facilities fall policy and procedure indicated a fall risk assessment would be completed at the time of admission to the facility. Each resident would receive adequate supervision and assistance to prevent resident falls. And, all residents new to the facility must have close monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure resident care plans are followed. The DON or designee could then	21850	DEFICIENCY)			

Minnesota Department of Health

PRINTED: 08/25/2016 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING _ 23242 08/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 **CORNERSTONE VILLA** BUHL, MN 55713 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG 21850 Continued From page 11 21850 TIME PERIOD FOR CORRECTION: Twenty One (21) days.

Minnesota Department of Health

STATE FORM

	POST-CERTIFICATION REVISIT REPORT									
IDENTIFIC	ER / SUPPLIEI CATION NUM		MULTIPLE CON A. Building	ISTRUCTION					DATE 0	F REVISIT
245612		Y1	B. Wing				UTY OTATE TUD O	12	9/20/20	Y3
	F FACILITY RSTONE VIL	ΙΔ			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724					
OOTHINE	TOTONE VIE					BUHL, MN 55713				
program corrected provision	, to show tho d and the da	se deficie e such co I the iden	ncies previously prrective action v	reported on the	e CMS-256 ed. Each d	edicaid and/or Clinica 7, Statement of Defici eficiency should be fune CMS-2567 (prefix o	encies and Plan outling identified using the contraction of the contra	of Correcti g either th	on, that e regula	have been ition or LSC
ITEI	М		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	F0323		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.25(h)		Completed	Reg. #		Completed	Reg. #			Completed
LSC			09/28/2016	LSC			LSC	***************************************		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #		Completed	Reg. #			Completed
LSC			_	LSC			LSC			
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Reg. # Completed		Reg. #		Completed	Reg. # Comp		Completed			
LSC			LSC			LSC				
REVIEWE STATE AC		REVIE (INITIA	WED BY LLS)	DATE	SIGNATU	TURE OF SURVEYOR			DATE	
REVIEWS CMS RO	ED BY	REVIE (INITIA	WED BY LLS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/23/2016					CORRECTED DEFICIENCIES (CMS-2567)			YE	s 🗆 no	

STATE FORM: REVISIT REPORT DATE OF REVISIT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / **IDENTIFICATION NUMBER** A. Building 9/28/2016 B. Wing 23242 **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 1000 FOREST STREET PO BOX 724 CORNERSTONE VILLA **BUHL, MN 55713** This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). DATE DATE **ITEM** ITEM DATE ITEM Y5 Y5 Y4 **Y4** Y5 Y4 Correction ID Prefix 20830 Correction ID Prefix 21850 Correction **ID Prefix** MN Rule 4658.0520 MN St. Statute 144.651 Reg. # Completed Reg. # Completed Reg. # Completed Subd. 14 Subp. 1 09/28/2016 09/28/2016 LSC LSC LSC **ID Prefix ID Prefix** Correction **ID Prefix** Correction Correction Completed Reg. # Completed Completed Reg. # Reg. # LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Completed Completed Reg. # Reg. # LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Completed Reg. # Completed Reg. # Completed Reg. # LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC **REVIEWED BY** DATE DATE **REVIEWED BY** SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) DATE DATE TITLE **REVIEWED BY REVIEWED BY** CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO 8/23/2016

Page 1 of 1

EVENT ID: