MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Cornerstone Villa

Facility Address:
1000 Forest Street

Facility City:
Buhl

State:	ZIP:	County:
Minnesota	55713	Saint Louis

Report Number:
H5612009

Time of Visit:
1:00 p.m. to 4:00 p.m.
9:30 a.m. to 4:30 p.m.

Date of Visit:
May 31, 2016 and June 1, 2016

Date Concluded:
December 21, 2016

Investigator's Name and Title:
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.

The resident's condition was so severe that a local hospital had to transfer the resident to a trauma center. The resident had sustained multiple facial fractures, requiring intubation to maintain a patent airway. After evaluation and considering the extent of resident's facial fractures, conservative care was chosen for resident and the resident died at the hospital two days later.

The resident's death certificate indicated the cause of death was complications from facial fractures after a fall.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had a policy in place that directed staff to provide each resident with adequate supervision and assistance to prevent falls. All residents new to the facility required close monitoring. The physical therapists assessed that the resident required contact guard assistance when ambulating and the resident's care plan indicated the resident needed assistance with ambulation. Multiple staff allowed the resident to ambulate independently.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

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 prevention. Staff were educated on the changes as well as communication with the therapy department. A follow-up visit was conducted to evaluate the non-compliance with regulations. The facility was found back in compliance in September 2016.

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:

Document Review: The following records were reviewed during the investigation:

Other pertinent medical records:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Facility Internal Investigation Reports
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? ○ Yes ○ No ○ N/A

Specify: _____

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) ○ Yes ○ No ◉ N/A

Specify: _____

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: ◉ Yes ○ No

Total number of staff interviews: 13

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☒ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◯ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Buhl Police Department

Saint Louis County Attorney

Buhl City Attorney

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 08/23/2016

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CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5612009. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure a safe environment when staff did not implement the individualized care plan developed to minimize the risk for falls for 1 of 3 residents (R1) reviewed for falls. The facility's failure resulted in actual harm (facial fractures leading to death) for R1. Findings include: R1's medical record was reviewed. R1's diagnosis list from admission on 05/04/2016, indicated R1 had a history of alzheimer/dementia, shortness of breath and wheezing, recurrent	F 323		

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

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urinary track infections, congestive heart failure, 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 alarm 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,

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indicated R1 was ambulating just prior to the fall. 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.

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 by herself.

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During an interview on 5/31/2016 at 3:40 p.m., RN-F indicated R1 should not have been walking around by herself because she had not been assessed yet. She said R1 was too unsteady to ambulate alone and R1 only knew who she was, not where she was and did not have a concept of time.

During an interview on 06/01/2016 at 10:30 a.m. social services (SS)-E indicated she did the admission for R1. She said PT evaluated R1 on 5/5/2016, recommending CGA only. SS-E said R1 should not have been walking by herself. SS-E conducted the investigation following R1's fall and stated LPN-B and RN-C indicated R1 was walking by herself before the fall. R1 was walking from one unit to the next unit. SS-E said R1 was only orientated to who she was.

During an interview on 06/01/2016, at 12:05 p.m. nursing assistant (NA)-A stated a staff person told her R1 was ambulating independently. NA-A said there was not a wanderguard or alarm on the wheelchair because R1 was being assessed for the risk of elopement. NA-A said she heard the front door alarm and when she got there and she found R1 on the ground outside the facility. NA-A said the walker was off to the left side and it appeared like R1 had lost her balance.

During an interview on 6/01/2016, at 12:30 p.m. Physical therapist (PT)-D indicated she evaluated R1 who needed a CGA at all times. PT-D stated R1 should not have been ambulating independently.

During an interview on 6/1/2016 at 12:55 p.m. Licensed Practical Nurse (LPN)-B stated after the evening meal, she saw R1 walking around the

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unit independently using a walker. She also said R1 was walking on another unit as well. LPN-B said R1 looked like she was looking at other 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.

Minnesota Department of Health

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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: 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, Division of Compliance Monitoring, Office of	2 000		

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

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2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a safe environment when staff did not implement the individualized care plan developed to minimize the risk for falls for 1 of 3 residents (R1) reviewed for falls. The facility's failure resulted in actual harm (facial fractures leading to death) for R1. Findings include: R1's medical record was reviewed. R1's diagnosis list from admission on 05/04/2016, indicated R1 had a history of alzheimer/dementia, shortness of breath and wheezing, recurrent urinary track infections, congestive heart failure,	2 830		

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2 830	Continued From page 2 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 alarm 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,	2 830		

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2 830	Continued From page 3 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. 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 by herself. During an interview on 5/31/2016 at 3:40 p.m., RN-F indicated R1 should not have been walking around by herself because she had not been	2 830		

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2 830	Continued From page 4 assessed yet. She said R1 was too unsteady to ambulate alone and R1 only knew who she was, not where she was and did not have a concept of time. During an interview on 06/01/2016 at 10:30 a.m. social services (SS)-E indicated she did the admission for R1. She said PT evaluated R1 on 5/5/2016, recommending CGA only. SS-E said R1 should not have been walking by herself. SS-E conducted the investigation following R1's fall and stated LPN-B and RN-C indicated R1 was walking by herself before the fall. R1 was walking from one unit to the next unit. SS-E said R1 was only orientated to who she was. During an interview on 06/01/2016, at 12:05 p.m. nursing assistant (NA)-A stated a staff person told her R1 was ambulating independently. NA-A said there was not a wanderguard or alarm on the wheelchair because R1 was being assessed for the risk of elopement. NA-A said she heard the front door alarm and when she got there and she found R1 on the ground outside the facility. NA-A said the walker was off to the left side and it appeared like R1 had lost her balance. During an interview on 6/01/2016, at 12:30 p.m. Physical therapist (PT)-D indicated she evaluated R1 who needed a CGA at all times. PT-D stated R1 should not have been ambulating independently. During an interview on 6/1/2016 at 12:55 p.m. Licensed Practical Nurse (LPN)-B stated after the evening meal, she saw R1 walking around the unit independently using a walker. She also said R1 was walking on another unit as well. LPN-B said R1 looked like she was looking at other people, but appeared not to have a purpose while	2 830		

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 08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

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2 830	Continued From page 5 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 compliance to resident care plans.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident was free from maltreatment when staff did not implement the individualized care plan developed to minimize the risk for falls for 1 of 3 residents (R1) reviewed for falls. The facility's failure resulted in actual harm (facial fractures leading to death) for R1. Findings include: R1's medical record was reviewed. R1's diagnosis list from admission on 05/04/2016, indicated R1 had a history of alzheimer/dementia, shortness of breath and wheezing, recurrent	21850		

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21850	Continued From page 7 urinary track infections, congestive heart failure, 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 alarm 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.	21850		

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21850	Continued From page 8 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. 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 by herself. During an interview on 5/31/2016 at 3:40 p.m., RN-F indicated R1 should not have been walking	21850		

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21850	Continued From page 9 around by herself because she had not been assessed yet. She said R1 was too unsteady to ambulate alone and R1 only knew who she was, not where she was and did not have a concept of time. During an interview on 06/01/2016 at 10:30 a.m. social services (SS)-E indicated she did the admission for R1. She said PT evaluated R1 on 5/5/2016, recommending CGA only. SS-E said R1 should not have been walking by herself. SS-E conducted the investigation following R1's fall and stated LPN-B and RN-C indicated R1 was walking by herself before the fall. R1 was walking from one unit to the next unit. SS-E said R1 was only orientated to who she was. During an interview on 06/01/2016, at 12:05 p.m. nursing assistant (NA)-A stated a staff person told her R1 was ambulating independently. NA-A said there was not a wanderguard or alarm on the wheelchair because R1 was being assessed for the risk of elopement. NA-A said she heard the front door alarm and when she got there and she found R1 on the ground outside the facility. NA-A said the walker was off to the left side and it appeared like R1 had lost her balance. During an interview on 6/01/2016, at 12:30 p.m. Physical therapist (PT)-D indicated she evaluated R1 who needed a CGA at all times. PT-D stated R1 should not have been ambulating independently. During an interview on 6/1/2016 at 12:55 p.m. Licensed Practical Nurse (LPN)-B stated after the evening meal, she saw R1 walking around the unit independently using a walker. She also said R1 was walking on another unit as well. LPN-B said R1 looked like she was looking at other	21850		

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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 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 compliance to resident care plans.	21850		

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21850	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21850		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245612 Y1	A. Building B. Wing Y2	9/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 BUHL, MN 55713

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 09/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
23242 Y1	A. Building B. Wing Y2	9/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET PO BOX 724 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 09/28/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 09/28/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: VW7312

STATE FORM: REVISIT REPORT (11/06)