STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245307	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Nsg & Rehab Center	416 Seventh Street Northeast Bagley, MN 56621

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to accurately assess pressure ulcers to include type of wound and staging for 2 of 3 residents (R2, R3) reviewed for pressure ulcers.Findings include:R2's Resident Face Sheet indicated she admitted to the facility 7/15/22. Diagnosis included Multiple Sclerosis, depression, spongiatic dermatitis (a skin condition characterized by inflammation and fluid buildup) and anxiety.R2's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she had upper and lower extremity impairments on both sides. The MDS indicated R2 was incontinent of bowel, was dependent on staff for toileting and transfers and had a stage II pressure ulcer (a partial-thickness skin injury that involves damage to the epidermis (outer layer of skin) and some of the dermis (middle layer of skin), present on admission.R2's Tisue Tolerance Test dated 7/16/25, identified a history of pressure ulcers and indicated R2 showed signs of redness at the three-hour mark. Staff to assist with repositioning every two hours and as needed.R2's Braden Scale for Predicting Pressure Ulcer Risk dated 7/30/25, identified high risk for pressure ulcer development.R2's care plan dated 8/14/25, identified a self- care deficit related to impaired mobility, pain, impaired cognition and inability to independently complete activities of daily living. The care plan identified an alteration in elimination, identified the use of a supra-pubic catheter, and bowel incontinence. The care plan further identified an alteration in skin related to impaired mobility and incontinence and indicated she had a chronic ulcer to buttock. The care plan indicated R2 had a stage II pressure sore to her buttock that came and went at baseline and directed staff to float heels, keep skin clean and dry and reposition every 2 - 3 hours in bed.R2's Wound Management Detail Reports identified other dermatitis.8/19/25, Wound type: Other dermatitis, .08cm x 0.5 cm. wound healing status stable.8/26/25, Wound type, other dermatitis. Right buttock, 0.8 centimeters (cm) x .5 cm. Wound healing status, stable. 9/11/25, Wound type: other dermatitis. Right buttock 0.5 cm x 0.5 cm. Wound healing status, improving. Open area noted on upper right buttocks. Small blue area noted in the middle. 3.7 cm x 2 cm.9/17/25, Other dermatitis, 1.2 cm x 1.5 cm, wound status improving, stable.Resident Progress Notes identified the following:8/6/25, Progress Note indicated R2 had some open areas noted throughout her buttocks.8/9/25, Progress Notes indicated open sores noted on buttocks, no signs of purulent drainage or foul odor.8/19/25, Progress Note indicated R2 had two open areas noted to buttocks measuring 0.8 cm x 1.2 cm. below that was 0.5 cm x 0.8 cm to left buttock.8/26/25, Progress Note indicated R2 had small open areas noted to left buttock. Had a history of opening and closing.9/5/25, Progress Note indicated R2 had shearing (a type of skin damage that occurs when two layers of skin or tissue slide over each other in opposite directions) noted to left and right inner buttocks. Coccyx had a darkened blue area measuring 1.7 cm x 0.4 cm.9/11/25, Progress Note indicated R2 had previously open area on left buttock, now healed. Right buttocks had open area noted. Red to wound bed with a blue center noted. Darkened area noted to buttocks measured 11 cm x 9 cm, blanchable.9/17/25, Progress Note indicated R2 had an open area to right buttock, smaller than previous week. Darkened area to buttock 11 cm x 9 cm, blanchable.9/26/25, R2's buttock Is macerated throughout. Skin seemed to be very moist. Small scabbed area to the right of the coccyx measuring 0.5cm around. Two smaller open areas to mid left buttock measuring 0.3cm.During observation on 9/26/25 at 1:17 p.m., with the director of nursing (DON), R2 was lying in bed. R2's buttocks had a darkened area approximately 6 inches x 6 inches. R2's buttocks was macerated with open areas present. On the right side of the coccyx were two small dark eschar (a patch of dead, dry, leathery tissue that forms over a wound bed, typically appearing black or dark brown and firmly attached to the underlying skin. Unlike a scab, which protects a superficial injury, an eschar is a sign of non-viable tissue resulting from severe burns, pressure ulcers, infections, or other trauma) areas on the upper right side of the wound. The DON stated the wound on the right side of R2's coccyx was pressure related. On the top left side of R2's coccyx was a small area covered in slough (type of non-viable dead tissue that forms in wounds. It is typically yellow, white, or gray in color and has a soft, moist, or stringy texture.) The DON stated the wound was also pressure related but was unable to stage the wound.R3's Resident Face Sheet indicated she admitted to the facility 6/8/2006. Diagnosis included Multiple Sclerosis, chronic osteomyelitis of right thigh, diabetes mellitus and stage IV pressure ulcer (a severe form of pressure injury that involves deep tissue damage, exposing muscle, tendon, or bone) of right buttock.R3's Tissue Tolerance Test dated 2/18/25, indicated a history of pressure ulcers and indicated she showed signs of redness over bony prominences at the three-hour mark. Staff to assist with