

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER Cornerstone Nsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a discharge Minimum Data Set (MDS) was completed and submitted to the Centers for Medicare and Medicaid (CMS) database as directed for 2 of 2 residents (R10, R12) reviewed for resident assessment task. Findings include: R10: R10's face sheet printed on 7/9/25, identified R10 was admitted on [DATE], and discharged on 2/25/25. R10's progress notes dated 1/13/25, identified R10 was admitted after a hospitalization from 12/30/24 through 1/13/25, due to respiratory failure, pneumonia and influenza. R10 was admitted on [DATE], for a short-term rehab stay and had planned to return to home. During R10's nursing home admission the resident received physical and occupational therapy for activities of daily living (ADL's), fall monitoring, pain monitoring, respiratory and medication management. R10's progress note dated 1/28/25 identified social services met with R10 regarding discharge planning and resident hoped to discharge home after rehab stay was complete. R10's progress notes dated 2/24/25, identified R10 would be discharged to home with in-home services on 2/25/25. R10's medical record lacked evidence there was a discharge MDS initiated, completed and submitted. R12: R12's undated face sheet, identified R12 was readmitted on [DATE], and discharged on 2/11/25. R12's entry tracking record MDS dated [DATE], identified R12 was re-admitted on [DATE], from a short-term general hospital. R12's quarterly MDS dated [DATE], identified the quarterly MDS was the first assessment since R12's most recent admission on [DATE], and R12 was readmitted from a short-term general hospital. There was no discharge date on the assessment. R12's nursing home progress note(s) identified the following: 1/23/25, identified R12 was admitted after having an amputation of the left 3rd toe. R12 had orders for antibiotics, therapy and daily dressing changes. 1/27/25, identified writer called the primary care physician, discussed findings of dressing changes since admission, and concerns regarding possible infection. R12 was transferred to the emergency room. 2/11/25, identified writer received a call from R12 requesting the resident's daughter and other family members to come and pack up his belongings to bring to him. An update to the note identified per review of hospital case management notes, resident mentioned multiple times his desire to transfer to a different facility following hospitalization. Hospital notes were placed into scanning. Staff accepted the communication as resident-initiated discharge. 2/26/25 at 12:12 p.m., identified discharge summary and discharge notification was faxed to the hospital case manager. A joint interview was conducted with registered nurse (RN)-C and RN-D on 7/9/25 at 1:31 p.m. RN-C stated when a resident was transferred to an acute care setting and expected to stay greater than 24 hours, a discharge with anticipated return MDS would be completed. When a resident was discharged to home a discharge MDS would be completed and MDS's should be completed within one week. RN-C completed R12's discharge with anticipated return MDS dated [DATE], and mistakenly completed a quarterly MDS dated [DATE]. RN-C should have completed a transmission error MDS for the quarterly MDS. R12 did not have a discharge MDS completed after resident was discharged from the nursing home on 2/11/25. RN-C failed to complete R10's discharge MDS. The assessment should have been completed by 2/25/25. The facility MDS/Resident Assessment policy signed 10/17/22, identified The MDS was completed for all residents in Medicare- or Medicaid-certified nursing homes. The facility will complete the MDS following the RAI manual and state requirements to assure each resident receives and accurate assessment that is reflective of each resident's status.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and document review the facility failed to ensure staff dishing and serving food to residents wore a hairnet in 1 of 4 dining rooms (400-unit) with the potential to affect all residents who resided on the 400 unit. Findings include:The undated facility census identified 8 residents resided on the 400-unit. During observation on 7/8/25 at 5:00 p.m., a staff member wheel a steam table onto the 400-unit dining area. Seven residents were seated at tables in the dining room and one resident was eating in the their room. Trained medication aide (TMA)-A was wearing gloves and without a hair net dished food from the steam table onto a plate and then delivering the plate to a resident. TMA-A continued dishing and delivering food until all residents in the dining room had plates of food in front of them.On 7/8/25 at 5:19 p.m., TMA-A stated when she worked on the 400 unit she worked as a nursing assistant and a TMA, and always dished and delivered food to the residents. There was not a dietary staff member that assisted during meals. TMA-A never wore or thought about wearing a hair net while dishing food from the steam table and had not been told to wear a hair net while dishing food. TMA-A stated it was important to wear a hair net while dishing food to prevent hair from falling into the resident's food and potentially spreading any bacteria from her hair.On 7/9/25 at 9:10 a.m., registered nurse (RN)-A, who was also the infection control nurse, stated dietary staff dished food from the steam table and serve to residents in the 100-unit and 200-unit dining room(s) and nursing staff dished food from the steam table and serve to the residents in the 300-unit and 400-unit dining rooms. All staff, including nursing staff, were required to wear gloves and hair net when serving food from the steam cart. All staff were educated and knew they were required to wear hair nets. RN-A stated wearing hair nets helped prevent hair from falling into the food and potentially preventing the spread of bacteria from hair and into the food. The undated facility Infection Control for the Dietary Department policy, identified dietary staff would practice proper food handling procedures, including hand washing, wearing hairnets or caps and clean uniforms, as well as practice proper food handling procedures, including wearing hair nets or caps.The facility Employee Hygiene for Food Safety policy dated 2023, identified all employees would wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.Section 2-402.11 of the FDA Food code dated 2017 identified A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. This is crucial to prevent cross-contamination. Staphylococcus aureus is an example of a common pathogen that is found on skin and hair. If enough of the bacteria is ingested, it could cause illness. Common symptoms of this illness include vomiting, nausea, and stomach cramps.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 2 of 5 residents (R2, R146) reviewed for wounds and 1 of 1 resident (R2) reviewed for catheter. Findings include:</p> <p>A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.</p> <p>R2:</p> <p>R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact, was dependent on staff for all activities of daily living (ADL's); R2 had an indwelling catheter, was at risk for pressure ulcers and had moisture associated skin damage (MASD). Interventions included pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, application of nonsurgical dressings and ointment to area's other than the feet. R2's diagnoses included multiple sclerosis (MS) and neurogenic bladder.</p> <p>R2's care plan reviewed 6/5/25, identified R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 was at risk of infection related to indwelling medical device and directed staff to maintain EBP per facility protocol. R2 had impaired mobility and was at risk for pressure ulcer/injury and was prone to periods of skin maceration due to chronic ulcer to buttock.</p> <p>R2's progress note dated 6/24/25, identified R2 had dressing changes to the coccyx area per wound care.</p> <p>R2's progress note dated 7/7/25, identified R2 the following:</p> <p>10 x10 centimeters (cm) darkened area around the coccyx.</p> <p>5.5 cm x 3.5 cm sheared open area that was red and draining mild amounts of serosanguinous drainage.</p> <p>1 cm x 1.5 cm area in the center that was darkened red and bleeding mildly.</p> <p>Nurse made a call to the doctor with an update and questioned if current wound appointment for 7/25/25 should be moved up.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encouraged R2 to stay off buttocks as much as possible.</p> <p>R2's progress notes failed to identify if R2 was on EBP.</p> <p>On 7/7/25 at 11:30 a.m., R2's door was observed and there was a sign identifying R2 was on EBP and there was a cart with PPE. R2 stated staff did not always wear a gown when emptying the resident's catheter.</p> <p>On 7/8/25 at 2:40 p.m., upon entering R2's room nursing assistant (NA)-C was observed standing next to R2's bed with a water basin on the bedside table and a folded washcloth in her gloved hand and was not wearing a gown. NA-C was wiping R2's suprapubic catheter tubing. NA-C stated R2 liked to get freshened up mid-day and in the evening. NA-C finished wiping the catheter and started to wipe R2's peri area, turned R2 on her side and began to wipe R2's coccyx area. NA-C stated she had been off for a few days and was unaware that R2's coccyx area was open, although the wound continually opened and healed. NA-C applied barrier cream to R2's coccyx area and proceeded to apply powder to groin area. NA-C finished dressing and getting R2 comfortable, removed gloves, collected garbage and exited the room. During interview, NA-C stated she typically wore PPE when freshening up R2. Staff were instructed to wear PPE for catheter and wound care. NA-C stated she had worn PPE including a gown and gloves when she completed catheter cares and cleansing R2's peri area and coccyx area, then threw the gown and gloves in the garbage, washed hands and put on clean gloves. NA-C stated that was when the state agent (SA) entered the room.</p> <p>On 7/8/25 at 3:52 p.m., R2 stated she couldn't remember if NA-C was wearing a gown when completing catheter care just recently, although staff hadn't always worn gowns while completing catheter or wound cares. Further, R2 stated it was important for staff to wear gowns, so they didn't spread infections her.</p> <p>R146:R146's entry tracking record MDS dated [DATE], identified R146 was admitted on [DATE].R146's undated Resident Face Sheet included diagnoses of sepsis (serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death), malignant neoplasm of colon, diabetes, congestive heart failure and bullous pemphigoid (rare skin condition that causes large fluid-filled blisters). R14's progress notes were reviewed from 6/30/25 to 7/8/25 and identified the following:</p> <p>6/30/25, an admission note identified R146 had scaly darkened skin on both her lower legs, which was a chronic issue for R146. R146 did have a history of open areas to her lower legs, however were not open on admission.</p> <p>7/2/25, skin note: an open area was noted on anterior shin of left leg that measured 5 cm length by 4.5 cm wide. The area was cleansed and antibiotic ointment was applied.</p> <p>7/3/25, weeping was noted on both lower extremities. Legs were cleansed and triple antibiotic ointment applied. An abdominal pad was applied and legs were wrapped with a gauze roll.</p> <p>7/4/25, R146's legs had weeping with a moderate amount of serosanguinous drainage. R146's legs were cleansed with normal saline, dressing were applied, covered with abdominal pad and wrapped with a gauze roll. R146's treatment administration record was updated to reflect the dressing change.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 7/7/25, at 1:30 p.m. licensed practical nurse (LPN)-A gathered dressing supplies and entered R146's room to change the leg dressings on R146's right and left legs. There was no signage or personal protective equipment cart set up near or in R146's room to identify if R146 required any type of precautions. R146 was lying in bed, visiting with three family members. LPN-A notified R146 and her family she was going to perform dressing changes to R146 wounds on her right and left calves and they could remain in the room, seated in chairs at the foot of R146's bed if they wished to. All three family members agreed to stay. LPN-A placed her dressing supplies on R146's window sill and went to the resident bathroom and washed her hands. LPN-A then put on gloves and started to remove the old dressing from R146's left leg. LPN-A stopped and put on R146's call light to request another staff member to assist her. Nursing assistant (NA)-A entered the room. NA-A was wearing a face mask and when asked to assist with the dressing change, washed her hands and put on gloves. LPN-A removed R146's old dressing from her left leg as NA-A held the leg up off R146's bed, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down and raised up R146's right leg. LPN-A changed her gloves and removed the old dressing from R146's right leg, exposing a large open area covering R146's front calf from ankle to mid calf and the entire width of the calf. A large 2 centimeter clear fluid filled blister was formed on the inner side of the wound. The open area was surface depth and red in color. LPN-A sprayed the wound with normal saline spray and patted dry with 4 x 4 gauze pads. LPN-A applied the ordered dressings to the wound and wrapped the leg with a gauze bandage roll. NA-A then set R146's leg down. LPN-A gathered up and disposed of the dressings in the resident's garbage, removed her gloves and exited the room. NA-A removed her gloves, washed her hands and exited the room. On 7/8/25, at 8:00 a.m. an EBP sign and personal protective equipment (PPE) cart was observed hanging on the outside of R146's room door. During interview on 7/8/25, at 8:30 a.m. LPN-A stated R146 should have been on EBP, but she had not been aware R146's wounds were open until she had performed wound care on 7/7/25. After performing wound care on 7/7/25, LPN-A notified the facility's registered nurse and they set up the PPE and signage. LPN-A stated she and NA-A should have been wearing a disposable gown as well as gloves to perform the wound care but they had not. When interviewed on 7/8/25, at 9:05 a.m. NA-A stated she should have been wearing a disposable gown when she had assisted LPN-A with R146's wound care. NA-A had been off for a few days and had not worked with R146 before. When she entered the room and they started removing R146's dressings she knew they should have donned gowns for the wound care but they were already into it and so just completed it and then NA-A went directly to the RN on and notified her of the open areas and need for PPE. The RN had not been aware the wounds were open and then they immediately setup the room for PPE and precautions. During interview on 7/8/25, at 10:30 a.m. the infection control registered nurse (RN)-A stated the facility initiated EBP for all residents with a urinary catheter, wound care, dressings, any invasive lines, and feeding tubes. RN-A reviewed all new admissions for invasive lines or wounds and usually had EBP precautions and signage setup before new admission arrived to the facility. If existing residents had changes or new open areas she usually noted it by reading the shift report notes or the nurse responsible would notify her, or the NA's if they notice something when doing resident cares. R146's legs did not have open areas present when she was admitted. As soon as she was notified of the open areas, she immediately initiated EBP. RN-A</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/8/25 at 4:17 p.m., the director of nursing (DON) stated staff were required to wear PPE, including gown and gloves, when completing direct patient care including working with indwelling medical devices or open wounds, and were expected to change gloves from dirty to clean, including before applying barrier cream and/or powders. Staff should not complete catheter care or wound care without wearing PPE. The Facility Enhanced Barrier Precautions policy dated 4/1/24, identified EBP would be utilized for high-risk residents during high contact care and activities to aide in the prevention of MDRO spread. Residents would be assessed . for indwelling medical devices (i.e.: urinary catheters) and for wounds that may require EBP. If a residents require any indwelling medical devices or meet the CDC wound requirements, they will be placed on EBP. EBP will be used for selected resident's wit high contact care and activity per CDC guidelines. EBP signs would be placed on the resident room doors to identify PPE required as well as defining high risk resident activities. Gowns, gloves and alcohol-based hand rub (ABHR) will be available to staff in EBP rooms. Gown and gloves will be donned prior to the high contact activity; they do not have to be donned prior to entering room. Gown and gloves will be doffed as well as hand hygiene completed prior to leaving the resident room or between care of residents in shared room.</p>