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	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Villa	1000 Forest Street Buhl, MN 55713

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790 Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who was at risk for elopement. This resulted in an immediate jeopardy (IJ) for R1 when she eloped from the facility and was found in the facility parking lot by a passersby. The IJ began on [DATE] at 8:44 p.m., when R1 wandered out of the facility. The administrator and director of nursing (DON) were informed of the IJ on [DATE] at 3:22 p.m. The facility had implemented corrective action on [DATE], prior to the start of the survey, and was therefore past noncompliance. Findings include: R1's Face Sheet dated [DATE], indicated R1 had vascular dementia. R1's care plan dated [DATE], indicated R1 was at risk for elopement, utilized a WanderGuard system (used to trigger alarms to alert staff when the resident is near an exit door). Interventions included monitor WanderGuard placement on walker every shift, and monitor function. Monitor and document any elopement attempts and wandering. R1's Provider Orders dated [DATE], directed to check WanderGuard placement every shift, and check signal strength of the WanderGuard every night. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had memory problems and severe cognitive impairment skills for daily decision making. The MDS indicated R1 had no wandering or exit seeking behaviors. R1's treatment administration record (TAR) for December, 2024 indicated R1's WanderGuard was checked on [DATE] evening shift and night shift, and on [DATE] day shift. The facility Risk Management Report Elopement dated [DATE], indicated R1 exited the facility with her walker unattended, and was returned to the facility via a passerby. The report lacked any further information. On [DATE] at 9:00 p.m., the temperature in [NAME] MN was 12 degrees Fahrenheit (F) with a wind of 10.7 miles per hour per World Weather. The wind chill was 2 degrees F. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Elopement Risk assessment dated [DATE] indicated R1 had some intermittent confusion, but no noted wandering. R1 had a purposeful destination in mind when she left her room was not at risk for elopement, but did have a WanderGuard on her walker per her preference. Review of the facility video footage dated [DATE] indicated R1 left the building at 8:44 p.m. and returned to the building at 9:02 p.m. R1 was noted to have a red winter coat and shoes on. R1's WanderGuard alarm did not sound as the WanderGuard was never placed on her walker or on her person. On [DATE] at 10:04 a.m., registered nurse (RN)-A stated on [DATE], during the day shift, she did not officially look at R1's walker to ensure the WanderGuard was present. However, she did document in the electronic medical record (EMR) she had checked for placement. It was an oversight on her part. On [DATE] at 10:13 a.m., licensed practical nurse (LPN)-A stated on [DATE], during the night shift, she didn't check R1's WanderGuard for placement or function. She did not make it to R1's room to check her WanderGuard that night, but she documented she had done it in R1's EMR. She had never checked for function for any resident's WanderGuard until receiving education on [DATE] when she was taught to check WanderGuard function. On [DATE] at 11:00 a.m., R1's medical doctor (MD)-A stated R1 was not able to make her own decisions and was not safe to leave the facility alone. If R1's WanderGuard was on her, she would have been intercepted before going outside. R1 was incredibly disoriented and would not have known to get back into the facility. She could have gotten hypothermia or been hit by a car as the facility was next to a highway, and even possibly died . On [DATE] at 11:40 a.m., the director of nursing (DON) stated staff were expected to check the placement of the WanderGuards every shift, and check the function of the WanderGuards every night. This was not occurring as staff were documenting it completed in the EMR, but were not actually completing the task. On [DATE] at 12:02 p.m., LPN-B stated on [DATE] around 8:45 p.m., R1 told her she needed to go somewhere. She redirected R1 to her room. About 15 to 20 minutes later, a family member came and got her, and told her R1 was outside. She went outside, and R1 was in a vehicle with a stranger. They stated they were from town, and saw R1 walking close to the road. They stopped and helped her into the car to drove her back to the facility. LPN-B assisted R1 out of the car, and back into the building. R1's WanderGuard alarm didn't sound, and then noticed R1 did not have a WanderGuard on. On [DATE] during the evening shift, she didn't check placement of R1's WanderGuard because she thought it had alarmed when R1 entered the double doors after an activity. The WanderGuard manufacture's manual directed to test WanderGuard signaling devices daily and record the results in the resident's records. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The past non-compliance immediate jeopardy began on [DATE]. The IJ was removed, and the deficient practice was corrected by [DATE], after the facility implemented a systemic plan that included the following actions: Reviewed their policies on use of WanderGuards, re-assessed all residents who were at risk for elopement to ensure they had a WanderGuard in place and in working order, and re-educated all nursing staff on the expectation of WanderGuard function and monitoring policies. The facility completed daily audits to ensure compliance, and will bring the results of the audits to the Quality Assurance and Performance Improvement (QAPI) committee. Verification of corrective action was confirmed by observation, interview, and document review on [DATE].