



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

RE: CCN: 245349

Cycle Start Date: June 18, 2026

Dear Administrator:

On June 18, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **September 18, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **December 18, 2026** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is stylized with a large, looped "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

Re: State Nursing Home Licensing Orders

Event ID: 231B47-H1

Dear Administrator:

The above facility survey was completed on June 18, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

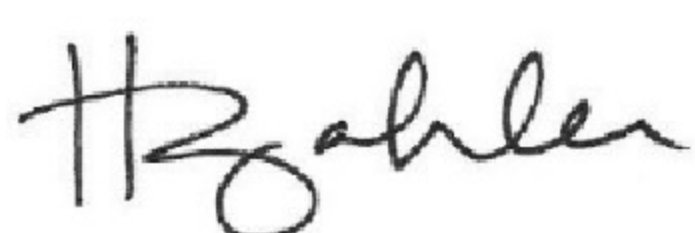
Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20000	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: On 6/15/26 to 6/18/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H53492889C (2610540), H53492886C (2739143),			20000			07/23/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 H53492885C (2739130), H53492890C (2561397), H53492884C (2805169). NO licensing orders were issued. The following complaints were reviewed: H53492887C (2653730). An incidental finding was discovered and issued at (F755). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000			07/23/2026	
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3		20565	Corrected		07/23/2026	

Minnesota Department of Health

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20565	Continued from page 2 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 3 resident (R4, R1) reviewed for hospice care and smoking. Findings Include: R4's quarterly Minimum Data Set (MDS) dated 5/12/26, indicated R4 was moderately cognitively impaired. R4's diagnosis included dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) with moderate agitation During record review on 6/16/26 at 10:01 a.m., noted R4 was admitted to hospice on 1/30/26. R4's comprehensive care plan failed to include a resident-specific hospice care plan, including hospice diagnosis, hospice provider information, and resident choices and preferences. During an interview on 6/16/26 at 1:24 p.m., registered nurse (RN)-A stated she is unsure why R4 was put on hospice, probably due to his infections or maybe his worsening dementia. RN-A stated she didn't know what end-of life preferences R4 had. During an interview on 6/16/26 at 1:27 p.m., Minimum Data Set (MDS)-A coordinator and RN-B stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident care plan and is updated to include pertinent hospice information. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. MDS-A confirmed R4 was admitted to hospice on 1/30/26. MDS-A confirmed R4's care plan did not have a hospice care plan. MDS-A and RN-B stated the hospice care plan is important, so all staff are aware of the resident status and how to care for him at the end-of-life stage. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered			20565			07/23/2026

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20565	Continued from page 3 interdisciplinary care plan. R1 R1's quarterly Minimum Data Set (MDS) assessmen, dated 5/11/26, indicated intact cognition, and R1 was independent with mobility. R1's ecord review indicated R1's had impaired vision related to macular degeneration and was legally blind. R1 was able to ambulate up and down the halls in the facility and outside of the facility only in the area of the railing safely. Smoking observation/assessment dated 7/31/25 indicated, R1's was able to smoke independently, requested staff assistance when ready to go out to smoke and smoked less than a cigarette a day. R1's record review lacked smoking care plan (problem, goals/outcomes, and interventions). During an interview on 06/17/26 08:15 a.m., administrator acknowledged, R1 was able to smoke safely with staff assistance and had no smoking care plan in place. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and perform measurable audits for additional residents' medical records to determine accuracy of their assessments. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20565			07/23/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of			20900	Corrected		07/23/2026

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20900	Continued from page 4 a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive weekly wound assessments for 1 of 1 resident (R6) reviewed for pressure Ulcer/Injury who had two unhealed stage 4 pressure ulcers (full-thickness skin and tissue loss, exposed bone, ligament, cartilage, or muscle) on bilateral buttocks. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings Include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/3/26, identified R6 had intact cognition and was dependent on staff for activities of daily living and mobility. MDS identified two stage 4 pressure ulcers, pressure reducing device for bed, chair and application of nonsurgical dressing and ointment. R6's diagnoses included stage 4 pressure on right and left buttock, hereditary spastic paraplegia (inherited disorders that cause progressive stiffness and weakness in the legs, often leading to mobility challenges). R6's care plan dated 6/10/26, directed staff to assess the pressure ulcer location, stage, size (length, width and depth), presence/ absence of granulation (healing) tissues, conduct a systematic skin inspection weekly and report any signs of further skin breakdown. R 6's wound treatment order dated 4/14/26 included: dressing plan for the bilateral open stage 4 ischial pressure injuries, continue to use Vashe (wound cleanser) barely moistened kerlix covered with ABD (thick multi-layered medical dressing) pad			20900			07/23/2026

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20900	Continued from page 5 held in place with silicone tape, 3 times daily. R6's Electronic Medical Record (EMR) review indicated R6 was hospitalized from 1/16/26 to 01/26/26 for progressive worsening of bilateral buttocks stage 4 pressure ulcers with concern for infection and a hospitalization from 05/14/26 to 5/18/26 for acute osteomyelitis (infection in a bone), both ischial (sit bones) wounds were open to bone and periosteum (connective tissues), with the left wound correlating with new osteomyelitis. Review of R6's EMR wound documentation identified 3 wound assessments and documentation in 90 days: On 3/31/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. bottom looked good overall with scant amount of maceration to peri wound. Left buttock wound measured; 4 cm(centimeters) L(length) x 7 cm W(width)x 7 cm D (depth),Right gluteal wound measuring 2 cm (L) x 3.5 cm (W) x 5.3 cm (D). On 04/2/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. Left buttock wound measured; 9.6 cm (L) x 5.2 cm (W) x 9.2 cm (D), Right gluteal wound measuring 3.5 cm (L) x 2.7 cm (W) x 5.0 cm (D). On 6/3/26, wound documentation current indicated: wound care completed this AM after resident had a shower. Left buttock wound measured 1.5cm x 2.0 cmx 4.0cm Right buttock wound measured 2.0 cm x 4.0 cm x 6.4.cm, no s/s of infection, no odor, no drainage, resident denies pain and tolerated treatment well. During an observation and interview on 6/17/2026 7:22 a.m., R6 stated, wounds dressing changes were completed by 7 a.m., between 12 p.m., and 2:00 p.m., and after 7:00 p.m., R6 said he spent most of the day in the facility apartment visiting his wife and returned to the facility for medications and treatments. During observation on 6/17/2026 1:40 p.m. R6 returned to the facility, took scheduled medications,			20900			07/23/2026

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20900	Continued from page 6 declined wound treatment and assessment, and returned to the facility apartment to visit his wife. During an interview on 06/17/26 12:50 p.m., licensed practical nurse, (LPN)-A stated, weekly wound assessment and documentation was completed by the nurse manager. During an interview on 06/17/26 10:57 a.m., interim director of nursing (IDON) stated, the expectation was all wounds would be measured and documented on weekly basis. During an interview on 06/17/26 at 2:33 p.m., licensed nurse practitioner (NP)-B expected facility staff to complete weekly wound assessment and report any issues identified. Facility policy title "Skin Integrity, Wound, Care and Pressure Injury Prevention" reviewed on 6/18/26 on indicated, all wound, and pressure injuries shall be assessed upon identification and monitored routinely thereafter. Assessment shall include Location, size and measurement, stage (if applicable), appearance of wound bed, drainage characteristics, sign and symptoms of infections, pain, periwound condition and response to treatment. Residents with existing wounds or pressure injuries shall have treatment goals and interventions reflected in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are accurately assessed and receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the facility quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			07/23/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by:			21550	Corrected		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21550	Continued from page 7 Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R37) reviewed for pharmacy services. Findings include: R37 face sheet indicated R37 admitted to the facility on 6/3/26. R37's admission Minimum Data Set (MDS) assessment, dated 6/9/26, indicated R37 was cognitively intact with no delirium and no behaviors. R37 had upper and lower body impairment and required assistance with all activities of daily living. The MDS also indicated R37 had diagnoses of anxiety and depression. R37's diagnoses list included heart disease, major depressive disorder, and generalized anxiety disorder. R37's care plan indicated R37 received an antianxiety medication related to anxiety disorder. R37's hospital discharge orders dated 6/3/26, indicated clonazepam (prescribed to treat anxiety)0.5 mg tablet give 1/2 tablet twice a day R37's Medication Administration Record (MAR) indicated R37 had an order for clonazepam 0.5 mg tablet. Give 1/2 tablet twice a day scheduled. The MAR further indicated R37 did not receive the clonazepam from 6/3/26 evening shift through 6/15/26 due to "drug not available." Additional notes on the MAR indicated on 6/3/26 "drug unavailable, resident informed. Will call pharmacy in the AM". On 6/5/26 evening shift the MAR also indicated "medication not found, also checked Ekit (emergency kit) not available". On 6/11/26 the MAR also indicated "no written script from pharm"(pharmacy). R37's progress notes indicated R37 was seen on 6/4/26 for a first post admission recertification with orders for labs placed. The progress notes also indicated R37 was seen at the facility by the nurse practitioner for an acute visit on 6/10/26. The progress notes lacked documentation a provider was updated of R37's clonazepam not being administered due to being unavailable. A hand written faxed document dated 6/4/26, to the medical director indicated "FYI. [facility pharmacy] needs an updated script for [R37] clonazepam."			21550			07/23/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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21550	Continued from page 8 Provider progress notes indicate the medical director was in the facility on 6/4/26 to sign R37's admission orders and R37 was seen for an acute visit on 6/10/26. Neither document mentioned needing a valid prescription for clonazepam. During an interview on 6/16/26 at 11:21 a.m., trained medication aide (TMA)-A stated if a medication was not found, she would look through all of the medication carts and call the pharmacy to order it. TMA-A stated staff "are not supposed to" document "unavailable" on the MAR. If a script is needed, she would tell the nurse on duty. When asked about R37's clonazepam, TMA-A stated "I think they were trying to get her off of that, I'm not really sure. I know it wasn't a prior authorization thing.". TMA-A looked through the medication cart and verified there was no card of clonazepam available. During an interview on 6/16/26 at 1:01 p.m., the pharmacy technician stated the pharmacy last filled 30 tablets of clonazepam for R37 on 11/6/25 and they do not have a current order for clonazepam for R37. During an interview on 6/16/26 at 1:08 p.m., licensed practical nurse (LPN)-A stated if a medication is not available the pharmacy is notified and a note is made in the progress notes. If the pharmacy states a new script is required, the provider is updated. LPN-A stated he does not work with R37 often but does recall one of the nurses stating messages were sent to the provider for the clonazepam order. LPN-A reviewed R37's progress notes and confirmed there is no documentation stating a provider was updated. LPN-A stated an SBAR (a note written to providers) is placed in the SBAR binder. LPN-A could not find documentation in the binder indicating a request for clonazepam was made. On 6/16/26 at 2:08 p.m., the administrator provided an SBAR that was written on 6/14/26 to the provider indicating "discontinue orders for Clonazepam BID. No script, has not taken while here". During interview on 6/16/26 at 2:21 p.m., the nurse practitioner (NP) stated she is at the facility weekly. The NP confirmed R37 was discharged from the hospital with an order for clonazepam 0.5 mg tablet 1/2 tablet twice a day. The NP also confirmed R37 was seen by the medical director on 6/4/26 and by her on 6/10/26 for an acute visit. The NP stated she was unaware R37 had not been receiving clonazepam and did not see any documentation or			21550			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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21550	Continued from page 9 fax indicating a request for a script for clonazepam. The NP stated she would expect to be notified immediately if a medication was unavailable. During an interview on 6/17/26 at 8:18 a.m., the assistant director of nursing (ADON) stated the facility has a binder with the procedure for obtaining medications that are controlled substances. The ADON stated if a medication is unavailable, staff are expected to check the emergency kit, reach out to the pharmacy, and reach out to the provider. The ADON stated she expects continued communication until the medication is available. The ADON confirmed the documentation the medication was not available. She stated she would expect the nursing staff to communicate with the providers at least every shift until the situation was rectified. The ADON confirmed the medical director was at the facility on 6/4/26 to certify R37's admission orders and the nurse practitioner saw R37 on 6/10/26 for an acute visit. The ADON confirmed there was no evidence a provider was notified of the clonazepam between the fax on 6/4/26 and the SBAR written 6/14/26. She stated the facility had ample opportunity to reach out to the providers to obtain the script for the clonazepam. A policy titled "Procedure for Addressing Controlled Substance/Narcotic Supply shortage" dated 11/5/25, indicated if it is a med we have in the emergency kit, first call the pharmacy (after hour pharmacy if that is appropriate) to see if you can access the emergency kit for the medication, if they say yes, do so and document/request replacement accordingly. But you will need to send a request for a refill if the pharmacy is not planning on sending more to the facility. If no, because there is not a valid Rx [prescription], then you will have to call the provider or the on-call provider for after hours. If they do it, ask them to be sure to send it to [pharmacy name]. It is then necessary to document what you have done and what the result is. If for some reason you are not able to get a medication, you need to monitor the resident, offer non-pharmacological interventions, and if that is not enough, call the family to notify and send the resident to the ED (emergency department). Notify facility DON by phone or email. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication was ordered, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the			21550			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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21550	Continued from page 10 disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days		21550			07/23/2026	
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessment to self-administer medications, was implemented and followed consistently in accordance with physician orders for 1 on 1 resident (R8) reviewed for self-administration of medications. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living (ADL) and maximal assistance with mobility. R8's care plan dated 05/04/26 indicated, resident would like to administer oral medications and be more independent with ADL's. Resident was unable to self-administer safely medications, may self-administer inhalers/nebs after set up only. R8's active medications list review included an order for R8 to self-administer inhalers and nebulizer treatments only after set up by staff and could not self-administer oral medications safely dated 11/09/23. R8's self-administration of medication assessment dated 4/18/26 indicated, R8 did not wish to self-administer any medications, had moderately impaired cognitive status, made poor decision, required cues/supervision and based on evaluation, it was not appropriate for R8 to self-administer any medications.		21565	Corrected		07/23/2026	

Minnesota Department of Health

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21565	Continued from page 11 During an observation on 06/16/26 4:09 p.m., R8 was found sitting in a wheelchair in the room, holding in the left hand a 1 oz medication cup containing 4 tablets and in the right hand, an 8 oz clear cup, containing water. When asked who provided the medications and water, R8 stated, the medications were from a while ago and was unable to recall who provided the medications. At 4:38 p.m., R8 was found in the same position, with no medication cup in the left hand and the water cup was placed on the nightstand. When R8 was asked what happened to the medications, R8 was unable to recall. Further inspection showed the medication cup and the 4 tablets of medication on the floor and a small amount of spilled water. R8 's call light was used and trained medication aid (TMA)-A and registered nurse (RN)-A at 4:40 p.m responded to the call light. During an interview on 06/16/26 at 4:41 p.m., (TMA)-A stated, R8 was not supposed to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff and was unsure who provided the medications found on the floor. RN-A also confirmed, R8 was not to self-administer any oral medications except inhalers and nebulizer treatments only after set up by staff and would notify supervisor immediately. Medications found on the floor were identified as tramadol 50 mg tablet, 2 tablets of Tylenol 500mg and calcium citrate 200mg tablet. During an interview on 06/17/26 at 10:30 a.m., administrator indicated a near miss medication investigation report was completed and trained medication aid (TMA)-B was identified as staff member involved. During an interview on 6/17/26 at 1:43 p.m., TMA-B stated, they had provided R8 with an inhaler first, which R8 self-administered after set up, then the 4 tablets in a medication cup and water on 6/16/26 at 4:30 p.m., TMA-B confirmed was aware R8 was unable to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff. TMA-B stated, was under the impression that R8 took the medications in her presence. During an interview on 06/18/2026 11:04 a.m., acting director of nursing (ADON), upon review of R8's self-administration of medication assessment dated 4/18/26 and confirmed, R8 was unable to self-administer any medications including inhalers and nebulizer treatments.			21565			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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21565	Continued from page 12 Facility policy titled “Self -Administration of Medication Policy “revised on 6/16/26 indicated, nursing staff shall review self-administration documentation routinely and ensure appropriate entries are reflected on the Medication Administration Record (MAR). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.			21565			07/23/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

RE: CCN: 245349

Cycle Start Date: June 18, 2026

Dear Administrator:

On June 18, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **September 18, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **December 18, 2026** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is stylized with a large, looped initial "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Electronically delivered

July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

Re: State Nursing Home Licensing Orders

Event ID: 231B47-H1

Dear Administrator:

The above facility survey was completed on June 18, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

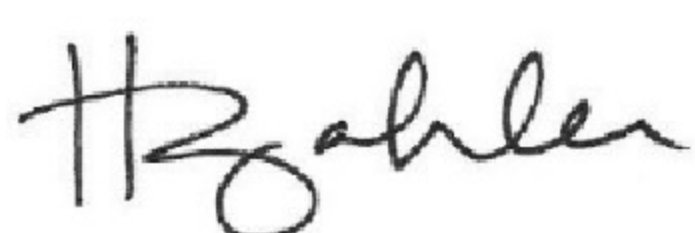
Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



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July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
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RE: CCN: 245349

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Dear Administrator:

On June 18, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **September 18, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **December 18, 2026** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is stylized with a large, looped "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
Stewartville Care Center
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

Re: State Nursing Home Licensing Orders

Event ID: 231B47-H1

Dear Administrator:

The above facility survey was completed on June 18, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

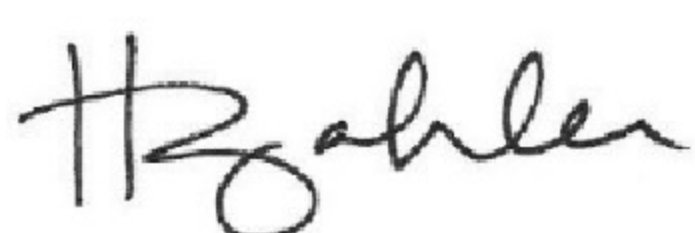
Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20000	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: On 6/15/26 to 6/18/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H53492889C (2610540), H53492886C (2739143),			20000			07/23/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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20000	Continued from page 1 H53492885C (2739130), H53492890C (2561397), H53492884C (2805169). NO licensing orders were issued. The following complaints were reviewed: H53492887C (2653730). An incidental finding was discovered and issued at (F755). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			07/23/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3			20565	Corrected		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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20565	Continued from page 2 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 3 resident (R4, R1) reviewed for hospice care and smoking. Findings Include: R4's quarterly Minimum Data Set (MDS) dated 5/12/26, indicated R4 was moderately cognitively impaired. R4's diagnosis included dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) with moderate agitation During record review on 6/16/26 at 10:01 a.m., noted R4 was admitted to hospice on 1/30/26. R4's comprehensive care plan failed to include a resident-specific hospice care plan, including hospice diagnosis, hospice provider information, and resident choices and preferences. During an interview on 6/16/26 at 1:24 p.m., registered nurse (RN)-A stated she is unsure why R4 was put on hospice, probably due to his infections or maybe his worsening dementia. RN-A stated she didn't know what end-of life preferences R4 had. During an interview on 6/16/26 at 1:27 p.m., Minimum Data Set (MDS)-A coordinator and RN-B stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident care plan and is updated to include pertinent hospice information. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. MDS-A confirmed R4 was admitted to hospice on 1/30/26. MDS-A confirmed R4's care plan did not have a hospice care plan. MDS-A and RN-B stated the hospice care plan is important, so all staff are aware of the resident status and how to care for him at the end-of-life stage. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered			20565			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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20565	Continued from page 3 interdisciplinary care plan. R1 R1's quarterly Minimum Data Set (MDS) assessmen, dated 5/11/26, indicated intact cognition, and R1 was independent with mobility. R1's ecord review indicated R1's had impaired vision related to macular degeneration and was legally blind. R1 was able to ambulate up and down the halls in the facility and outside of the facility only in the area of the railing safely. Smoking observation/assessment dated 7/31/25 indicated, R1's was able to smoke independently, requested staff assistance when ready to go out to smoke and smoked less than a cigarette a day. R1's record review lacked smoking care plan (problem, goals/outcomes, and interventions). During an interview on 06/17/26 08:15 a.m., administrator acknowledged, R1 was able to smoke safely with staff assistance and had no smoking care plan in place. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and perform measurable audits for additional residents' medical records to determine accuracy of their assessments. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20565			07/23/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of			20900	Corrected		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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20900	Continued from page 4 a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive weekly wound assessments for 1 of 1 resident (R6) reviewed for pressure Ulcer/Injury who had two unhealed stage 4 pressure ulcers (full-thickness skin and tissue loss, exposed bone, ligament, cartilage, or muscle) on bilateral buttocks. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings Include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/3/26, identified R6 had intact cognition and was dependent on staff for activities of daily living and mobility. MDS identified two stage 4 pressure ulcers, pressure reducing device for bed, chair and application of nonsurgical dressing and ointment. R6's diagnoses included stage 4 pressure on right and left buttock, hereditary spastic paraplegia (inherited disorders that cause progressive stiffness and weakness in the legs, often leading to mobility challenges). R6's care plan dated 6/10/26, directed staff to assess the pressure ulcer location, stage, size (length, width and depth), presence/ absence of granulation (healing) tissues, conduct a systematic skin inspection weekly and report any signs of further skin breakdown. R 6's wound treatment order dated 4/14/26 included: dressing plan for the bilateral open stage 4 ischial pressure injuries, continue to use Vashe (wound cleanser) barely moistened kerlix covered with ABD (thick multi-layered medical dressing) pad			20900			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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20900	Continued from page 5 held in place with silicone tape, 3 times daily. R6's Electronic Medical Record (EMR) review indicated R6 was hospitalized from 1/16/26 to 01/26/26 for progressive worsening of bilateral buttocks stage 4 pressure ulcers with concern for infection and a hospitalization from 05/14/26 to 5/18/26 for acute osteomyelitis (infection in a bone), both ischial (sit bones) wounds were open to bone and periosteum (connective tissues), with the left wound correlating with new osteomyelitis. Review of R6's EMR wound documentation identified 3 wound assessments and documentation in 90 days: On 3/31/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. bottom looked good overall with scant amount of maceration to peri wound. Left buttock wound measured; 4 cm(centimeters) L(length) x 7 cm W(width)x 7 cm D (depth),Right gluteal wound measuring 2 cm (L) x 3.5 cm (W) x 5.3 cm (D). On 04/2/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. Left buttock wound measured; 9.6 cm (L) x 5.2 cm (W) x 9.2 cm (D), Right gluteal wound measuring 3.5 cm (L) x 2.7 cm (W) x 5.0 cm (D). On 6/3/26, wound documentation current indicated: wound care completed this AM after resident had a shower. Left buttock wound measured 1.5cm x 2.0 cmx 4.0cm Right buttock wound measured 2.0 cm x 4.0 cm x 6.4.cm, no s/s of infection, no odor, no drainage, resident denies pain and tolerated treatment well. During an observation and interview on 6/17/2026 7:22 a.m., R6 stated, wounds dressing changes were completed by 7 a.m., between 12 p.m., and 2:00 p.m., and after 7:00 p.m., R6 said he spent most of the day in the facility apartment visiting his wife and returned to the facility for medications and treatments. During observation on 6/17/2026 1:40 p.m. R6 returned to the facility, took scheduled medications,			20900			07/23/2026

Minnesota Department of Health

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20900	Continued from page 6 declined wound treatment and assessment, and returned to the facility apartment to visit his wife. During an interview on 06/17/26 12:50 p.m., licensed practical nurse, (LPN)-A stated, weekly wound assessment and documentation was completed by the nurse manager. During an interview on 06/17/26 10:57 a.m., interim director of nursing (IDON) stated, the expectation was all wounds would be measured and documented on weekly basis. During an interview on 06/17/26 at 2:33 p.m., licensed nurse practitioner (NP)-B expected facility staff to complete weekly wound assessment and report any issues identified. Facility policy title "Skin Integrity, Wound, Care and Pressure Injury Prevention" reviewed on 6/18/26 on indicated, all wound, and pressure injuries shall be assessed upon identification and monitored routinely thereafter. Assessment shall include Location, size and measurement, stage (if applicable), appearance of wound bed, drainage characteristics, sign and symptoms of infections, pain, periwound condition and response to treatment. Residents with existing wounds or pressure injuries shall have treatment goals and interventions reflected in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are accurately assessed and receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the facility quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			07/23/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by:			21550	Corrected		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21550	Continued from page 7 Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R37) reviewed for pharmacy services. Findings include: R37 face sheet indicated R37 admitted to the facility on 6/3/26. R37's admission Minimum Data Set (MDS) assessment, dated 6/9/26, indicated R37 was cognitively intact with no delirium and no behaviors. R37 had upper and lower body impairment and required assistance with all activities of daily living. The MDS also indicated R37 had diagnoses of anxiety and depression. R37's diagnoses list included heart disease, major depressive disorder, and generalized anxiety disorder. R37's care plan indicated R37 received an antianxiety medication related to anxiety disorder. R37's hospital discharge orders dated 6/3/26, indicated clonazepam (prescribed to treat anxiety)0.5 mg tablet give 1/2 tablet twice a day R37's Medication Administration Record (MAR) indicated R37 had an order for clonazepam 0.5 mg tablet. Give 1/2 tablet twice a day scheduled. The MAR further indicated R37 did not receive the clonazepam from 6/3/26 evening shift through 6/15/26 due to "drug not available." Additional notes on the MAR indicated on 6/3/26 "drug unavailable, resident informed. Will call pharmacy in the AM". On 6/5/26 evening shift the MAR also indicated "medication not found, also checked Ekit (emergency kit) not available". On 6/11/26 the MAR also indicated "no written script from pharm"(pharmacy). R37's progress notes indicated R37 was seen on 6/4/26 for a first post admission recertification with orders for labs placed. The progress notes also indicated R37 was seen at the facility by the nurse practitioner for an acute visit on 6/10/26. The progress notes lacked documentation a provider was updated of R37's clonazepam not being administered due to being unavailable. A hand written faxed document dated 6/4/26, to the medical director indicated "FYI. [facility pharmacy] needs an updated script for [R37] clonazepam."			21550			07/23/2026

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21550	Continued from page 8 Provider progress notes indicate the medical director was in the facility on 6/4/26 to sign R37's admission orders and R37 was seen for an acute visit on 6/10/26. Neither document mentioned needing a valid prescription for clonazepam. During an interview on 6/16/26 at 11:21 a.m., trained medication aide (TMA)-A stated if a medication was not found, she would look through all of the medication carts and call the pharmacy to order it. TMA-A stated staff "are not supposed to" document "unavailable" on the MAR. If a script is needed, she would tell the nurse on duty. When asked about R37's clonazepam, TMA-A stated "I think they were trying to get her off of that, I'm not really sure. I know it wasn't a prior authorization thing.". TMA-A looked through the medication cart and verified there was no card of clonazepam available. During an interview on 6/16/26 at 1:01 p.m., the pharmacy technician stated the pharmacy last filled 30 tablets of clonazepam for R37 on 11/6/25 and they do not have a current order for clonazepam for R37. During an interview on 6/16/26 at 1:08 p.m., licensed practical nurse (LPN)-A stated if a medication is not available the pharmacy is notified and a note is made in the progress notes. If the pharmacy states a new script is required, the provider is updated. LPN-A stated he does not work with R37 often but does recall one of the nurses stating messages were sent to the provider for the clonazepam order. LPN-A reviewed R37's progress notes and confirmed there is no documentation stating a provider was updated. LPN-A stated an SBAR (a note written to providers) is placed in the SBAR binder. LPN-A could not find documentation in the binder indicating a request for clonazepam was made. On 6/16/26 at 2:08 p.m., the administrator provided an SBAR that was written on 6/14/26 to the provider indicating "discontinue orders for Clonazepam BID. No script, has not taken while here". During interview on 6/16/26 at 2:21 p.m., the nurse practitioner (NP) stated she is at the facility weekly. The NP confirmed R37 was discharged from the hospital with an order for clonazepam 0.5 mg tablet 1/2 tablet twice a day. The NP also confirmed R37 was seen by the medical director on 6/4/26 and by her on 6/10/26 for an acute visit. The NP stated she was unaware R37 had not been receiving clonazepam and did not see any documentation or			21550			07/23/2026

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21550	Continued from page 9 fax indicating a request for a script for clonazepam. The NP stated she would expect to be notified immediately if a medication was unavailable. During an interview on 6/17/26 at 8:18 a.m., the assistant director of nursing (ADON) stated the facility has a binder with the procedure for obtaining medications that are controlled substances. The ADON stated if a medication is unavailable, staff are expected to check the emergency kit, reach out to the pharmacy, and reach out to the provider. The ADON stated she expects continued communication until the medication is available. The ADON confirmed the documentation the medication was not available. She stated she would expect the nursing staff to communicate with the providers at least every shift until the situation was rectified. The ADON confirmed the medical director was at the facility on 6/4/26 to certify R37's admission orders and the nurse practitioner saw R37 on 6/10/26 for an acute visit. The ADON confirmed there was no evidence a provider was notified of the clonazepam between the fax on 6/4/26 and the SBAR written 6/14/26. She stated the facility had ample opportunity to reach out to the providers to obtain the script for the clonazepam. A policy titled "Procedure for Addressing Controlled Substance/Narcotic Supply shortage" dated 11/5/25, indicated if it is a med we have in the emergency kit, first call the pharmacy (after hour pharmacy if that is appropriate) to see if you can access the emergency kit for the medication, if they say yes, do so and document/request replacement accordingly. But you will need to send a request for a refill if the pharmacy is not planning on sending more to the facility. If no, because there is not a valid Rx [prescription], then you will have to call the provider or the on-call provider for after hours. If they do it, ask them to be sure to send it to [pharmacy name]. It is then necessary to document what you have done and what the result is. If for some reason you are not able to get a medication, you need to monitor the resident, offer non-pharmacological interventions, and if that is not enough, call the family to notify and send the resident to the ED (emergency department). Notify facility DON by phone or email. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication was ordered, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the			21550			07/23/2026

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21550	Continued from page 10 disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days		21550			07/23/2026	
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessment to self-administer medications, was implemented and followed consistently in accordance with physician orders for 1 on 1 resident (R8) reviewed for self-administration of medications. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living (ADL) and maximal assistance with mobility. R8's care plan dated 05/04/26 indicated, resident would like to administer oral medications and be more independent with ADL's. Resident was unable to self-administer safely medications, may self-administer inhalers/nebs after set up only. R8's active medications list review included an order for R8 to self-administer inhalers and nebulizer treatments only after set up by staff and could not self-administer oral medications safely dated 11/09/23. R8's self-administration of medication assessment dated 4/18/26 indicated, R8 did not wish to self-administer any medications, had moderately impaired cognitive status, made poor decision, required cues/supervision and based on evaluation, it was not appropriate for R8 to self-administer any medications.		21565	Corrected		07/23/2026	

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21565	Continued from page 11 During an observation on 06/16/26 4:09 p.m., R8 was found sitting in a wheelchair in the room, holding in the left hand a 1 oz medication cup containing 4 tablets and in the right hand, an 8 oz clear cup, containing water. When asked who provided the medications and water, R8 stated, the medications were from a while ago and was unable to recall who provided the medications. At 4:38 p.m., R8 was found in the same position, with no medication cup in the left hand and the water cup was placed on the nightstand. When R8 was asked what happened to the medications, R8 was unable to recall. Further inspection showed the medication cup and the 4 tablets of medication on the floor and a small amount of spilled water. R8 's call light was used and trained medication aid (TMA)-A and registered nurse (RN)-A at 4:40 p.m responded to the call light. During an interview on 06/16/26 at 4:41 p.m., (TMA)-A stated, R8 was not supposed to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff and was unsure who provided the medications found on the floor. RN-A also confirmed, R8 was not to self-administer any oral medications except inhalers and nebulizer treatments only after set up by staff and would notify supervisor immediately. Medications found on the floor were identified as tramadol 50 mg tablet, 2 tablets of Tylenol 500mg and calcium citrate 200mg tablet. During an interview on 06/17/26 at 10:30 a.m., administrator indicated a near miss medication investigation report was completed and trained medication aid (TMA)-B was identified as staff member involved. During an interview on 6/17/26 at 1:43 p.m., TMA-B stated, they had provided R8 with an inhaler first, which R8 self-administered after set up, then the 4 tablets in a medication cup and water on 6/16/26 at 4:30 p.m., TMA-B confirmed was aware R8 was unable to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff. TMA-B stated, was under the impression that R8 took the medications in her presence. During an interview on 06/18/2026 11:04 a.m., acting director of nursing (ADON), upon review of R8's self-administration of medication assessment dated 4/18/26 and confirmed, R8 was unable to self-administer any medications including inhalers and nebulizer treatments.			21565			07/23/2026

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21565	Continued from page 12 Facility policy titled “Self -Administration of Medication Policy “revised on 6/16/26 indicated, nursing staff shall review self-administration documentation routinely and ensure appropriate entries are reflected on the Medication Administration Record (MAR). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.			21565			07/23/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/17/2026. At the time of this survey, STEWARTVILLE CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/23/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. STEWARTVILLE CARE CENTER is a one-story building with lower-level exposed to grade It was constructed at two different times. The original building was constructed in 1970 and was determine to be of Type II (111) construction. In 1974 and addition was constructed and was determined to be of Type II (111) construction. Because the original building and additions are compatible construction types, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.			K0000			07/23/2026

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K0000 Bldg. 01	Continued from page 2 The facility has a capacity of 58 beds and had a census of 45 at the time of the survey.			K0000			07/23/2026
K0372 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:			K0372	Plan of Correction		07/23/2026
	Subdivision of Building Spaces - Smoke Barrie				K0372 – Fire and Smoke Dampers		
	CFR(s): NFPA 101				Corrective Action for Affected Areas		
	Subdivision of Building Spaces - Smoke Barrier Construction				The facility has a contract in place with a qualified licensed fire protection company to complete the required inspection and operational testing of all fire and smoke dampers throughout the facility. Any deficiencies identified during the inspection and testing process are repaired or replaced in accordance with applicable code requirements. Documentation of all testing, inspections, repairs, and corrective actions are maintained on-site. The facility has contacted the vendor to schedule service and is awaiting a return call to set the date.		
	2012 EXISTING				Identification of Other Potentially Affected Areas		
	Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.				All fire and smoke dampers located throughout the facility will be included in the inspection and testing process to ensure compliance. A complete inventory of fire and smoke dampers is used to verify that all required dampers are identified and included in all inspection schedules.		
	19.3.7.3, 8.6.7.1(1)				Systemic Changes		
	Describe any mechanical smoke control system in REMARKS.				The facility has reviewed and revised as necessary, its preventative maintenance program to include:		
	This STANDARD is NOT MET as evidenced by:				A complete inventory of all fire and smoke dampers.		
	Based on a review of available documentation, and staff interview, the facility failed to properly maintain fire/smoke dampers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 8.4.6.2, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.5.2. This deficient finding could have a widespread impact on the residents within the facility.				A recurring inspection and testing schedule consistent with requirements.		
	Findings include:				A tracking system identifying the location of each damper, date of the last inspection, next inspection due date, and documentation of any repairs completed.		
	On 06/17/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that fire / smoke damper testing was last completed – 02/09/2022.						
	An interview with the Maintenance Director verified this deficient finding at the time of discovery.						

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K0372 SS = F Bldg. 01				K0372	Continued from page 3 Assignment of responsibility to the Maintenance/Building and Grounds Director (or designee) for ensuring inspections are scheduled and completed prior to the required compliance dates. Review of contractor reports following each inspection to ensure all identified deficiencies are corrected promptly. Quality Assurance Monitoring The Maintenance/Building and Grounds Director will review the preventative maintenance schedule and ensure this process is scheduled on the facilities internal work order system to verify that all required Life Safety Code inspections remain current. The Administrator will review Life Safety compliance with this requirement and plan of correction by ensuring that this task is added to the internal work order system to be completed every four (4) years per regulations. Any identified concerns will be addressed immediately, and corrective actions will be implemented as necessary. Completion Date All corrective actions will be completed on or before July 23, 2026. The facility alleges compliance with K0372 on July 23, 2026.		07/23/2026
K0374 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides			K0374	Plan of Correction K0374 – Subdivision of Building Spaces (Smoke Barrier Doors) Corrective Action for Affected Areas The identified smoke barrier door(s) found to be out of compliance were evaluated by the Maintenance/Building and Grounds Director. Adjustments and/or repairs were completed to restore proper alignment, latching, and sealing. Following adjustment and/or repair, the smoke barrier door(s) were tested to verify they close completely, latch securely, and provide an effective		07/23/2026

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K0374 SS = F Bldg. 01	Continued from page 4 a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/17/2026 at 11:00 AM, it was revealed by observation that the smoke barrier door assembly adjacent to RM 119 did not close and seal the opening upon test. 2. On 06/17/2026 at 11:15 AM, it was revealed by observation that the smoke barrier door assembly for the EAST corridor did not close and seal the opening upon test. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0374	Continued from page 4 smoke-resistant barrier in accordance with applicable Life Safety Code requirements. Identification of Other Potentially Affected Areas The Maintenance/Building and Grounds Director completed an inspection of all smoke barrier doors throughout the facility to verify proper operation, self-closing, latching, alignment, and sealing. Any deficiencies identified during the inspection were corrected or added to the facility's maintenance work order system for immediate repair. Systemic Changes The facility has reviewed and revised as necessary, its preventative maintenance program to include: Routine inspections of all smoke barrier doors to verify proper closure, latching, alignment, and sealing. Documentation of all inspections, repairs, and adjustments. Education for maintenance personnel and other facility staff regarding Life Safety Code requirements for smoke barrier doors and the importance of maintaining smoke compartment integrity. Immediate repair or replacement of damaged hardware, seals, or door components whenever deficiencies are identified. Quality Assurance Monitoring The Maintenance/Building and Grounds Director (or designee) will inspect all smoke barrier doors monthly for three months and routinely thereafter as part of the facility's preventative maintenance program. Inspection results and any corrective actions will be documented and reviewed by the Administrator during the facility's monthly safety meetings for the next three (3) months. Any identified deficiencies will be corrected promptly. Completion Date		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/17/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0374 SS = F Bldg. 01				K0374	Continued from page 5		07/23/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 06/17/2026 at 11:25 AM, it was revealed by observation in the Laundry Chute Room (Main Floor) that the chute intake door was found in a propped			K0541	Plan of Correction K0541 – Linen and Trash Chutes Corrective Action for the Identified Deficiency The identified linen chute door was immediately inspected by the Maintenance/Building and Grounds Director. The door that was propped open, failed to self-close or positively latch was repaired or adjusted. Following completion of repairs, the chute door was tested to verify proper self-closing and positive latching. Identification of Other Potentially Affected Areas There are no other areas of concern in the facility with only a single chute being present in the facility. The door at the bottom of the chute was found to be in compliance. Systemic Changes The facility has revised its preventative maintenance program to include: Routine inspection of the linen chute door to verify propping is not noted, proper self-closing, positive latching, and overall condition. Documentation of all inspections, testing, repairs, and maintenance activities. Education of maintenance personnel and all staff regarding the Life Safety Code requirements for chute doors and the importance of maintaining the fire-resistance integrity of the chute system. Prompt repair or replacement of defective hardware whenever deficiencies are identified.		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/17/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0541 SS = F Bldg. 01	Continued from page 6 open position – not providing proper seal the vertical shaft opening. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0541	Continued from page 6 Quality Assurance Monitoring The Maintenance/Building and Grounds Director (or designee) will inspect the linen chute doors weekly for four (4) weeks and monthly thereafter for three (3) months to ensure continued compliance. Inspection results and any corrective actions will be documented and reviewed by the Administrator during the facility's monthly safety meetings for the next three (3) months. Any trends or recurring issues will result in additional corrective action and staff education. Completion Date All corrective actions will be completed on or before July 14, 2026. The facility alleges compliance with K0541 on July 23, 2026.		07/23/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding			K0761	Plan of Correction K0761 – Maintenance of Hazardous Area Doors Corrective Action for the Identified Deficiency The identified hazardous area door was immediately inspected by the Maintenance/Building and Grounds Director. The door was repaired and adjusted to ensure proper alignment, self-closing, and positive latching. Any damaged hardware, hinges, closers, or latching mechanisms were repaired or replaced. Following repair, the door was tested to verify proper operation and compliance with Life Safety Code requirements. Identification of Other Potentially Affected Areas The Maintenance/Building and Grounds Director completed a facility-wide inspection of all hazardous area doors to verify that each door closes completely, latches securely, and is free of damage that would compromise its fire and smoke resistance. Any additional deficiencies identified were corrected immediately or entered into the maintenance work order system for prompt repair. Systemic Changes		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/17/2026	
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K0761 SS = F Bldg. 01	Continued from page 7 could have a widespread impact on the residents within the facility. Findings include: On 06/17/2026 at 11:20 AM, it was revealed by observation that the fire rated door (Kitchen to Dining Room) did not close and seal the opening upon test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 7 The facility has revised its preventative maintenance program to include: Routine inspection of all hazardous area doors to verify proper self-closing, positive latching, alignment, and overall condition. Documentation of all inspections, testing, repairs, and maintenance performed. Education for maintenance personnel and other facility staff regarding Life Safety Code requirements for hazardous area doors and the importance of maintaining the integrity of fire and smoke barriers. Prompt repair or replacement of any damaged door components whenever deficiencies are identified. Quality Assurance Monitoring The Maintenance/Building and Grounds Director (or designee) will inspect all hazardous area doors monthly for three months and routinely thereafter as part of the facility's preventative maintenance program. Inspection results and any corrective actions will be documented and reviewed by the Administrator during the facility's monthly safety meetings for the next three (3) months. Any identified trends or recurring issues will be addressed through additional corrective action and staff education. Completion Date All corrective actions will be completed on or before June 19, 2026. The facility alleges compliance with K0761 on July 23, 2026.		07/23/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and			K0918	Plan of Correction K0918 – Electrical Systems – Essential Electric System (Generator Load Testing, Fuel Testing, and Battery Maintenance) Corrective Action for Affected Areas		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/17/2026	
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K0918 SS = F Bldg. 01	Continued from page 8 associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, documentation review and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3, 8.3.8, and 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/17/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that last annual inspection and load-bank testing of the emergency generator was completed – 04/11/2025. 2. On 06/17/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to			K0918	Continued from page 8 Upon identification of the deficiency, the facility evaluated the emergency power supply system to ensure it remained operational. Interim measures were implemented as necessary until all required testing and maintenance could be completed. The batteries were replaced on July 6, 2026. Identification of Other Potentially Affected Areas The facility reviewed and renewed its contract with the professional service contractor to ensure that an appointment could be made to complete the required load testing and added the annual fuel testing to the existing contract. (The annual fuel testing is a new requirement that the facility was notified of during the survey process). The facility has contacted the vendor to schedule service and is awaiting a return call to set the date. Systemic Changes The facility has implemented the following measures to prevent recurrence: The Maintenance/Building and Grounds Director reviewed all NFPA requirements related to generator inspections, exercising, load testing, fuel quality testing, and battery maintenance. A preventive maintenance schedule has been revised to include: Monthly generator exercise and inspection. Required annual or triennial load bank testing, as applicable. Scheduled fuel quality testing in accordance with NFPA requirements. Routine inspection, testing, cleaning, and timely replacement of generator starting batteries based on manufacturer recommendations and battery condition. A compliance calendar with due dates and reminders has been established to ensure all required testing and maintenance are completed on schedule.		07/23/2026

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K0918 SS = F Bldg. 01	Continued from page 9 confirm that annual emergency generator fuel testing is occurring. 3. On 06/17/2026 between 9:00 AM and 2:00 PM, it was revealed by observation and a review of available documentation that the emergency generator battery(s) were dated – 07/2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918	Continued from page 9 Maintenance staff have been educated on emergency power system requirements, documentation expectations, and applicable NFPA standards. Service records and testing documentation will be maintained and readily available for regulatory review. Quality Assurance Monitoring The Maintenance/Building and Grounds Director will Review generator inspection and maintenance records monthly for three (3) months to verify all required testing has been completed. Verify completion and documentation of generator exercise, load testing, fuel testing, and battery inspections according to the preventive maintenance schedule. Report compliance findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. The QAPI Committee will review trends, address any identified deficiencies, and determine if additional monitoring is warranted. Completion Date All corrective actions will be completed on or before July 23, 2026. The facility alleges compliance with K0918 on July 23, 2026.		07/23/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire			K0923	Plan of Correction K0923 – Medical Gas Storage – Oxygen Cylinders Unsecured and Stored with Combustible Materials Corrective Action for Affected Areas Upon identification of the deficiency, all unsecured oxygen cylinders were immediately secured in an approved storage rack or stand to prevent tipping. Combustible materials were removed from the oxygen storage area to eliminate the fire hazard. The affected storage area was inspected to ensure compliance with applicable NFPA requirements. Identification of Other Potentially Affected Areas To protect all residents, the facility conducted an		07/23/2026

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K0923 SS = F Bldg. 01	Continued from page 10 protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2.3, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/17/2026 at 11:30 AM, it was revealed by observation that the Main Floor - Med Gas (O2) Room was found unsecured and contained combustible storage. 2. On 06/17/2026 at 12:05 PM, it was revealed by observation that the Lower-level Med Gas (O2) Room had free-standing / unsecured cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0923	Continued from page 10 inspection of all oxygen storage locations throughout the building to verify that full and empty oxygen cylinders are properly secured at all times. Oxygen cylinders are stored in designated areas that are free of combustible materials. Appropriate separation of oxygen cylinders from combustible materials and ignition sources is maintained in accordance with NFPA requirements. Oxygen storage areas are properly identified and maintained. Any deficiencies identified during the facility-wide inspection were corrected immediately. Systemic Changes The facility has implemented the following measures to prevent recurrence: The Maintenance/Building and Grounds Director reviewed all designated oxygen storage locations to ensure compliance with NFPA requirements. Oxygen storage procedures have been reviewed and reinforced with nursing, maintenance, and other staff responsible for handling or storing oxygen cylinders. Staff education was provided regarding: Proper securing of oxygen cylinders to prevent tipping. Approved oxygen storage practices. Prohibition of storing combustible materials in oxygen storage areas. Fire safety precautions associated with medical gas storage. Routine environmental rounds have been updated to include verification that oxygen cylinders remain secure and that oxygen storage areas remain free of combustible materials. Oxygen storage compliance has been incorporated into the facility's preventive maintenance and Life		07/23/2026

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K0923 SS = F Bldg. 01				K0923	Continued from page 11 Safety inspection program. Quality Assurance Monitoring The Maintenance/Building and Grounds Director or designee will conduct weekly inspections of all oxygen storage locations for one month, followed by monthly inspections for an additional two months. Verify that all oxygen cylinders remain properly secured and that no combustible materials are stored in designated oxygen storage areas. Document inspection findings and immediately correct any identified deficiencies. Report compliance findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review compliance trends and determine whether additional monitoring is necessary. Completion Date All corrective actions will be completed on or before July 15, 2026. The facility alleges compliance with K0923 on July 23, 2026.		07/23/2026
K0712 SS = C Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. This deficient finding could have a widespread impact on the residents within the facility.			K0712	Plan of Correction K0712 – Fire Drills (Randomness of Date and Time Separation) Corrective Action for Affected Areas Upon identification of the deficiency, the facility reviewed its fire drill records and developed a revised fire drill schedule to ensure drills are conducted at varying and unpredictable times and dates in accordance with Life Safety Code requirements. Identification of Other Potentially Affected Areas The facility reviewed the fire drill program for all shifts and ensured future drills will be conducted at varying times and on varying dates to adequately test staff response under different conditions. Systemic Changes		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/17/2026	
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K0712 SS = C Bldg. 01	Continued from page 12 Findings include: On 06/17/2026 between 9:00 AM and 2:00 PM, it was revealed by review of available documentation that conducted fire drills exhibited lack of randomness in date and time separation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712	Continued from page 12 The facility has reviewed and revised as necessary, its fire drill program to include: Revision of the annual fire drill schedule to ensure drills are conducted at unexpected and varying times. Ensuring fire drills are separated sufficiently by date and time and are not conducted on a predictable pattern. Conducting fire drills on all shifts throughout the year as required by NFPA and CMS regulations. Education of personnel responsible for scheduling and documenting fire drills regarding Life Safety Code requirements for drill frequency, timing, and randomness. Maintaining documentation of fire drill dates, times, shifts, staff participation, and drill critiques. Quality Assurance Monitoring The Maintenance/Building and Grounds Director will review the fire drill schedule and ensure this process is scheduled on the facilities internal work order system to verify that all required drills remain complaint with the requirements. The Administrator will review each fire drill immediately following completion to verify compliance with scheduling requirements. Audit fire drill documentation quarterly for one year to ensure that drills continue to occur on varying dates and times. Implement corrective action immediately if any predictable scheduling pattern is identified. Present audit findings to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for review and follow-up as needed. Any identified concerns will be addressed immediately, and corrective actions will be implemented as necessary. Completion Date All corrective actions will be completed on or before July 15, 2026.		07/23/2026

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K0712 SS = C Bldg. 01				K0712	Continued from page 13 The facility alleges compliance with K0712 on July 23, 2026.		07/23/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2026

Administrator
STEWARTVILLE CARE CENTER
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

Re: Reinspection Results
Event ID: 231B47-H2

Dear Administrator:

On August 10, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 18, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 18, 2026

Administrator
STEWARTVILLE CARE CENTER
120 FOURTH STREET NORTHEAST
STEWARTVILLE, MN 55976

RE: CCN: 245349

Cycle Start Date: June 18, 2026

Dear Administrator:

On August 10, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
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20000	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: On 6/15/26 to 6/18/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H53492889C (2610540), H53492886C (2739143),			20000			07/23/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H53492885C (2739130), H53492890C (2561397), H53492884C (2805169). NO licensing orders were issued. The following complaints were reviewed: H53492887C (2653730). An incidental finding was discovered and issued at (F755). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			07/23/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3			20565	Corrected		07/23/2026

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20565	Continued from page 2 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 3 resident (R4, R1) reviewed for hospice care and smoking. Findings Include: R4's quarterly Minimum Data Set (MDS) dated 5/12/26, indicated R4 was moderately cognitively impaired. R4's diagnosis included dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) with moderate agitation During record review on 6/16/26 at 10:01 a.m., noted R4 was admitted to hospice on 1/30/26. R4's comprehensive care plan failed to include a resident-specific hospice care plan, including hospice diagnosis, hospice provider information, and resident choices and preferences. During an interview on 6/16/26 at 1:24 p.m., registered nurse (RN)-A stated she is unsure why R4 was put on hospice, probably due to his infections or maybe his worsening dementia. RN-A stated she didn't know what end-of life preferences R4 had. During an interview on 6/16/26 at 1:27 p.m., Minimum Data Set (MDS)-A coordinator and RN-B stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident care plan and is updated to include pertinent hospice information. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. MDS-A confirmed R4 was admitted to hospice on 1/30/26. MDS-A confirmed R4's care plan did not have a hospice care plan. MDS-A and RN-B stated the hospice care plan is important, so all staff are aware of the resident status and how to care for him at the end-of-life stage. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered			20565			07/23/2026

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20565	Continued from page 3 interdisciplinary care plan. R1 R1's quarterly Minimum Data Set (MDS) assessmen, dated 5/11/26, indicated intact cognition, and R1 was independent with mobility. R1's ecord review indicated R1's had impaired vision related to macular degeneration and was legally blind. R1 was able to ambulate up and down the halls in the facility and outside of the facility only in the area of the railing safely. Smoking observation/assessment dated 7/31/25 indicated, R1's was able to smoke independently, requested staff assistance when ready to go out to smoke and smoked less than a cigarette a day. R1's record review lacked smoking care plan (problem, goals/outcomes, and interventions). During an interview on 06/17/26 08:15 a.m., administrator acknowledged, R1 was able to smoke safely with staff assistance and had no smoking care plan in place. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to policy or procedure changes and perform measurable audits for additional residents' medical records to determine accuracy of their assessments. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20565			07/23/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of			20900	Corrected		07/23/2026

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20900	Continued from page 4 a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive weekly wound assessments for 1 of 1 resident (R6) reviewed for pressure Ulcer/Injury who had two unhealed stage 4 pressure ulcers (full-thickness skin and tissue loss, exposed bone, ligament, cartilage, or muscle) on bilateral buttocks. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings Include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/3/26, identified R6 had intact cognition and was dependent on staff for activities of daily living and mobility. MDS identified two stage 4 pressure ulcers, pressure reducing device for bed, chair and application of nonsurgical dressing and ointment. R6's diagnoses included stage 4 pressure on right and left buttock, hereditary spastic paraplegia (inherited disorders that cause progressive stiffness and weakness in the legs, often leading to mobility challenges). R6's care plan dated 6/10/26, directed staff to assess the pressure ulcer location, stage, size (length, width and depth), presence/ absence of granulation (healing) tissues, conduct a systematic skin inspection weekly and report any signs of further skin breakdown. R 6's wound treatment order dated 4/14/26 included: dressing plan for the bilateral open stage 4 ischial pressure injuries, continue to use Vashe (wound cleanser) barely moistened kerlix covered with ABD (thick multi-layered medical dressing) pad			20900			07/23/2026

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20900	Continued from page 5 held in place with silicone tape, 3 times daily. R6's Electronic Medical Record (EMR) review indicated R6 was hospitalized from 1/16/26 to 01/26/26 for progressive worsening of bilateral buttocks stage 4 pressure ulcers with concern for infection and a hospitalization from 05/14/26 to 5/18/26 for acute osteomyelitis (infection in a bone), both ischial (sit bones) wounds were open to bone and periosteum (connective tissues), with the left wound correlating with new osteomyelitis. Review of R6's EMR wound documentation identified 3 wound assessments and documentation in 90 days: On 3/31/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. bottom looked good overall with scant amount of maceration to peri wound. Left buttock wound measured; 4 cm(centimeters) L(length) x 7 cm W(width)x 7 cm D (depth),Right gluteal wound measuring 2 cm (L) x 3.5 cm (W) x 5.3 cm (D). On 04/2/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. Left buttock wound measured; 9.6 cm (L) x 5.2 cm (W) x 9.2 cm (D), Right gluteal wound measuring 3.5 cm (L) x 2.7 cm (W) x 5.0 cm (D). On 6/3/26, wound documentation current indicated: wound care completed this AM after resident had a shower. Left buttock wound measured 1.5cm x 2.0 cmx 4.0cm Right buttock wound measured 2.0 cm x 4.0 cm x 6.4.cm, no s/s of infection, no odor, no drainage, resident denies pain and tolerated treatment well. During an observation and interview on 6/17/2026 7:22 a.m., R6 stated, wounds dressing changes were completed by 7 a.m., between 12 p.m., and 2:00 p.m., and after 7:00 p.m., R6 said he spent most of the day in the facility apartment visiting his wife and returned to the facility for medications and treatments. During observation on 6/17/2026 1:40 p.m. R6 returned to the facility, took scheduled medications,			20900			07/23/2026

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20900	Continued from page 6 declined wound treatment and assessment, and returned to the facility apartment to visit his wife. During an interview on 06/17/26 12:50 p.m., licensed practical nurse, (LPN)-A stated, weekly wound assessment and documentation was completed by the nurse manager. During an interview on 06/17/26 10:57 a.m., interim director of nursing (IDON) stated, the expectation was all wounds would be measured and documented on weekly basis. During an interview on 06/17/26 at 2:33 p.m., licensed nurse practitioner (NP)-B expected facility staff to complete weekly wound assessment and report any issues identified. Facility policy title "Skin Integrity, Wound, Care and Pressure Injury Prevention" reviewed on 6/18/26 on indicated, all wound, and pressure injuries shall be assessed upon identification and monitored routinely thereafter. Assessment shall include Location, size and measurement, stage (if applicable), appearance of wound bed, drainage characteristics, sign and symptoms of infections, pain, periwound condition and response to treatment. Residents with existing wounds or pressure injuries shall have treatment goals and interventions reflected in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are accurately assessed and receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The results of the audits could be brought to the facility quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			07/23/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by:			21550	Corrected		07/23/2026

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21550	Continued from page 7 Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R37) reviewed for pharmacy services. Findings include: R37 face sheet indicated R37 admitted to the facility on 6/3/26. R37's admission Minimum Data Set (MDS) assessment, dated 6/9/26, indicated R37 was cognitively intact with no delirium and no behaviors. R37 had upper and lower body impairment and required assistance with all activities of daily living. The MDS also indicated R37 had diagnoses of anxiety and depression. R37's diagnoses list included heart disease, major depressive disorder, and generalized anxiety disorder. R37's care plan indicated R37 received an antianxiety medication related to anxiety disorder. R37's hospital discharge orders dated 6/3/26, indicated clonazepam (prescribed to treat anxiety)0.5 mg tablet give 1/2 tablet twice a day R37's Medication Administration Record (MAR) indicated R37 had an order for clonazepam 0.5 mg tablet. Give 1/2 tablet twice a day scheduled. The MAR further indicated R37 did not receive the clonazepam from 6/3/26 evening shift through 6/15/26 due to "drug not available." Additional notes on the MAR indicated on 6/3/26 "drug unavailable, resident informed. Will call pharmacy in the AM". On 6/5/26 evening shift the MAR also indicated "medication not found, also checked Ekit (emergency kit) not available". On 6/11/26 the MAR also indicated "no written script from pharm"(pharmacy). R37's progress notes indicated R37 was seen on 6/4/26 for a first post admission recertification with orders for labs placed. The progress notes also indicated R37 was seen at the facility by the nurse practitioner for an acute visit on 6/10/26. The progress notes lacked documentation a provider was updated of R37's clonazepam not being administered due to being unavailable. A hand written faxed document dated 6/4/26, to the medical director indicated "FYI. [facility pharmacy] needs an updated script for [R37] clonazepam."			21550			07/23/2026

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21550	Continued from page 8 Provider progress notes indicate the medical director was in the facility on 6/4/26 to sign R37's admission orders and R37 was seen for an acute visit on 6/10/26. Neither document mentioned needing a valid prescription for clonazepam. During an interview on 6/16/26 at 11:21 a.m., trained medication aide (TMA)-A stated if a medication was not found, she would look through all of the medication carts and call the pharmacy to order it. TMA-A stated staff "are not supposed to" document "unavailable" on the MAR. If a script is needed, she would tell the nurse on duty. When asked about R37's clonazepam, TMA-A stated "I think they were trying to get her off of that, I'm not really sure. I know it wasn't a prior authorization thing.". TMA-A looked through the medication cart and verified there was no card of clonazepam available. During an interview on 6/16/26 at 1:01 p.m., the pharmacy technician stated the pharmacy last filled 30 tablets of clonazepam for R37 on 11/6/25 and they do not have a current order for clonazepam for R37. During an interview on 6/16/26 at 1:08 p.m., licensed practical nurse (LPN)-A stated if a medication is not available the pharmacy is notified and a note is made in the progress notes. If the pharmacy states a new script is required, the provider is updated. LPN-A stated he does not work with R37 often but does recall one of the nurses stating messages were sent to the provider for the clonazepam order. LPN-A reviewed R37's progress notes and confirmed there is no documentation stating a provider was updated. LPN-A stated an SBAR (a note written to providers) is placed in the SBAR binder. LPN-A could not find documentation in the binder indicating a request for clonazepam was made. On 6/16/26 at 2:08 p.m., the administrator provided an SBAR that was written on 6/14/26 to the provider indicating "discontinue orders for Clonazepam BID. No script, has not taken while here". During interview on 6/16/26 at 2:21 p.m., the nurse practitioner (NP) stated she is at the facility weekly. The NP confirmed R37 was discharged from the hospital with an order for clonazepam 0.5 mg tablet 1/2 tablet twice a day. The NP also confirmed R37 was seen by the medical director on 6/4/26 and by her on 6/10/26 for an acute visit. The NP stated she was unaware R37 had not been receiving clonazepam and did not see any documentation or			21550			07/23/2026

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21550	Continued from page 9 fax indicating a request for a script for clonazepam. The NP stated she would expect to be notified immediately if a medication was unavailable. During an interview on 6/17/26 at 8:18 a.m., the assistant director of nursing (ADON) stated the facility has a binder with the procedure for obtaining medications that are controlled substances. The ADON stated if a medication is unavailable, staff are expected to check the emergency kit, reach out to the pharmacy, and reach out to the provider. The ADON stated she expects continued communication until the medication is available. The ADON confirmed the documentation the medication was not available. She stated she would expect the nursing staff to communicate with the providers at least every shift until the situation was rectified. The ADON confirmed the medical director was at the facility on 6/4/26 to certify R37's admission orders and the nurse practitioner saw R37 on 6/10/26 for an acute visit. The ADON confirmed there was no evidence a provider was notified of the clonazepam between the fax on 6/4/26 and the SBAR written 6/14/26. She stated the facility had ample opportunity to reach out to the providers to obtain the script for the clonazepam. A policy titled "Procedure for Addressing Controlled Substance/Narcotic Supply shortage" dated 11/5/25, indicated if it is a med we have in the emergency kit, first call the pharmacy (after hour pharmacy if that is appropriate) to see if you can access the emergency kit for the medication, if they say yes, do so and document/request replacement accordingly. But you will need to send a request for a refill if the pharmacy is not planning on sending more to the facility. If no, because there is not a valid Rx [prescription], then you will have to call the provider or the on-call provider for after hours. If they do it, ask them to be sure to send it to [pharmacy name]. It is then necessary to document what you have done and what the result is. If for some reason you are not able to get a medication, you need to monitor the resident, offer non-pharmacological interventions, and if that is not enough, call the family to notify and send the resident to the ED (emergency department). Notify facility DON by phone or email. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication was ordered, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the			21550			07/23/2026

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21550	Continued from page 10 disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days		21550			07/23/2026	
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessment to self-administer medications, was implemented and followed consistently in accordance with physician orders for 1 on 1 resident (R8) reviewed for self-administration of medications. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living (ADL) and maximal assistance with mobility. R8's care plan dated 05/04/26 indicated, resident would like to administer oral medications and be more independent with ADL's. Resident was unable to self-administer safely medications, may self-administer inhalers/nebs after set up only. R8's active medications list review included an order for R8 to self-administer inhalers and nebulizer treatments only after set up by staff and could not self-administer oral medications safely dated 11/09/23. R8's self-administration of medication assessment dated 4/18/26 indicated, R8 did not wish to self-administer any medications, had moderately impaired cognitive status, made poor decision, required cues/supervision and based on evaluation, it was not appropriate for R8 to self-administer any medications.		21565	Corrected		07/23/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
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21565	Continued from page 11 During an observation on 06/16/26 4:09 p.m., R8 was found sitting in a wheelchair in the room, holding in the left hand a 1 oz medication cup containing 4 tablets and in the right hand, an 8 oz clear cup, containing water. When asked who provided the medications and water, R8 stated, the medications were from a while ago and was unable to recall who provided the medications. At 4:38 p.m., R8 was found in the same position, with no medication cup in the left hand and the water cup was placed on the nightstand. When R8 was asked what happened to the medications, R8 was unable to recall. Further inspection showed the medication cup and the 4 tablets of medication on the floor and a small amount of spilled water. R8 's call light was used and trained medication aid (TMA)-A and registered nurse (RN)-A at 4:40 p.m responded to the call light. During an interview on 06/16/26 at 4:41 p.m., (TMA)-A stated, R8 was not supposed to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff and was unsure who provided the medications found on the floor. RN-A also confirmed, R8 was not to self-administer any oral medications except inhalers and nebulizer treatments only after set up by staff and would notify supervisor immediately. Medications found on the floor were identified as tramadol 50 mg tablet, 2 tablets of Tylenol 500mg and calcium citrate 200mg tablet. During an interview on 06/17/26 at 10:30 a.m., administrator indicated a near miss medication investigation report was completed and trained medication aid (TMA)-B was identified as staff member involved. During an interview on 6/17/26 at 1:43 p.m., TMA-B stated, they had provided R8 with an inhaler first, which R8 self-administered after set up, then the 4 tablets in a medication cup and water on 6/16/26 at 4:30 p.m., TMA-B confirmed was aware R8 was unable to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff. TMA-B stated, was under the impression that R8 took the medications in her presence. During an interview on 06/18/2026 11:04 a.m., acting director of nursing (ADON), upon review of R8's self-administration of medication assessment dated 4/18/26 and confirmed, R8 was unable to self-administer any medications including inhalers and nebulizer treatments.			21565			07/23/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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21565	Continued from page 12 Facility policy titled “Self -Administration of Medication Policy “revised on 6/16/26 indicated, nursing staff shall review self-administration documentation routinely and ensure appropriate entries are reflected on the Medication Administration Record (MAR). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.			21565			07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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E0000	Initial Comments On 6/15/26 to 6/18/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			07/23/2026
F0000	INITIAL COMMENTS On 6/15/26 to 6/18/26, a standard recertification survey (S5349041) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53492889C (2610540), H53492886C (2739143), H53492885C (2739130), H53492890C (2561397), H53492884C (2805169). NO deficiencies were cited. The following complaint was reviewed: H53492887C (2653730). An incidental finding was discovered and cited at (F755). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations			F0000			07/23/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
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F0000	Continued from page 1 has been attained.			F0000			07/23/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident assessment to self-administer medications, was implemented and followed consistently in accordance with physician orders for 1 on 1 resident (R8) reviewed for self-administration of medications. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living (ADL) and maximal assistance with mobility. R8's care plan dated 05/04/26 indicated, resident would like to administer oral medications and be more independent with ADL's. Resident was unable to self-administer safely medications, may self-administer inhalers/nebs after set up only. R8's active medications list review included an order for R8 to self-administer inhalers and nebulizer treatments only after set up by staff and could not self-administer oral medications safely dated 11/09/23. R8's self-administration of medication assessment dated 4/18/26 indicated, R8 did not wish to self-administer any medications, had moderately impaired cognitive status, made poor decision, required cues/supervision and based on evaluation, it was not appropriate for R8 to self-administer any medications. During an observation on 06/16/26 4:09 p.m., R8 was found sitting in a wheelchair in the room,			F0554	Plan of Correction Deficiency: F0554 Self-Administration of Medications 1. Corrective Action for Resident Found Affected Resident 8 identified during the survey was immediately assessed by the interdisciplinary team to determine appropriateness for self-administration of medications. The resident continues to be unable to self-administer oral medications but able to self-administer inhalers while witnessed and after setting up. Care plan remains current and appropriate. A near-miss medication event investigation was completed on June 17,2026 to ensure appropriate follow-up, education, tracking and quality improvement. It was determined that the resident did not miss any scheduled medications. 2. Identification of Other Residents Who May Be Affected The Assistant Director of Nursing, or designee, will conduct a comprehensive review of all residents currently approved for self-administration of medications to verify: A current physician order authorizing self-administration is present. A completed and current self-administration assessment is on file. The resident continues to demonstrate the ability to safely self-administer medications. Medications are securely stored in accordance with facility policy. Controlled substances, if approved for self-administration, are secured and accounted for in accordance with applicable regulations and facility policy.		07/23/2026

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F0554 SS = D	Continued from page 2 holding in the left hand a 1 oz medication cup containing 4 tablets and in the right hand, an 8 oz clear cup, containing water. When asked who provided the medications and water, R8 stated, the medications were from a while ago and was unable to recall who provided the medications. At 4:38 p.m., R8 was found in the same position, with no medication cup in the left hand and the water cup was placed on the nightstand. When R8 was asked what happened to the medications, R8 was unable to recall. Further inspection showed the medication cup and the 4 tablets of medication on the floor and a small amount of spilled water. R8 's call light was used and trained medication aid (TMA)-A and registered nurse (RN)-A at 4:40 p.m responded to the call light. During an interview on 06/16/26 at 4:41 p.m., (TMA)-A stated, R8 was not supposed to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff and was unsure who provided the medications found on the floor. RN-A also confirmed, R8 was not to self-administer any oral medications except inhalers and nebulizer treatments only after set up by staff and would notify supervisor immediately. Medications found on the floor were identified as tramadol 50 mg tablet, 2 tablets of Tylenol 500mg and calcium citrate 200mg tablet. During an interview on 06/17/26 at 10:30 a.m., administrator indicated a near miss medication investigation report was completed and trained medication aid (TMA)-B was identified as staff member involved. During an interview on 6/17/26 at 1:43 p.m., TMA-B stated, they had provided R8 with an inhaler first, which R8 self-administered after set up, then the 4 tablets in a medication cup and water on 6/16/26 at 4:30 p.m., TMA-B confirmed was aware R8 was unable to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff. TMA-B stated, was under the impression that R8 took the medications in her presence. During an interview on 06/18/2026 11:04 a.m., acting director of nursing (ADON), upon review of R8's self-administration of medication assessment dated 4/18/26 and confirmed, R8 was unable to self-administer any medications including inhalers and nebulizer treatments.			F0554	Continued from page 2 The resident's care plan accurately reflects self-administration abilities. Required documentation is complete and current. Any deficiencies identified during the audit will be corrected immediately. 3. Systemic Changes to Prevent Recurrence The facility has reviewed its Self-Administration of Medications policy to ensure compliance with: CMS Requirements of Participation. Applicable Minnesota statutes and regulations governing medication administration in long-term care facilities. Professional standards of nursing practice. The following corrective measures have been implemented: A standardized Self-Administration Assessment tool will be completed prior to approval for self-administration and at least quarterly, upon significant change in condition, following hospitalization, or whenever staff identify concerns regarding the resident's ability to safely self-administer medications. Self-administration requires an active provider order. Licensed nursing staff and trained medical aides will receive education regarding: CMS and Minnesota requirements for self-administration. Resident assessment criteria. Documentation requirements.		07/23/2026

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F0554 SS = D	Continued from page 3 Facility policy titled "Self -Administration of Medication Policy "revised on 6/16/26 indicated, nursing staff shall review self-administration documentation routinely and ensure appropriate entries are reflected on the Medication Administration Record (MAR).			F0554	Continued from page 3 Safe medication storage. Ongoing monitoring of resident competency. Care plans will be reviewed and updated as needed following each assessment or change in self-administration status. 4. Monitoring to Ensure Continued Compliance The Assistant Director of Nursing, or designee will complete compliance audits as follows: Weekly audits of all residents approved for self-administration for four (4) consecutive weeks. Monthly audits thereafter for two (2) additional months. Audits will verify: Current physician authorization. Completed and current self-administration assessment. Residents continue to safely meet criteria for self-administration. Medications are properly secured. Care plan reflects current medication management. Documentation is complete and accurate. Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the		07/23/2026

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F0554 SS = D				F0554	Continued from page 4 facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved. Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education. Completion date: July 23, 2026		07/23/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the			F0582	Plan of Correction Deficiency: F0582 – Providing Beneficiary Notices 1. Corrective Action for Resident Found Affected Resident 27 identified during the survey was immediately reviewed to determine whether all required Medicare beneficiary notices had been provided in accordance with CMS requirements. Any missing or incomplete beneficiary notices were issued promptly to the resident and/or the resident's legal representative, as appropriate. Documentation of notice delivery, including the date, time, method of delivery, recipient, and acknowledgment of receipt (when applicable), was completed and placed in the resident's medical record. The interdisciplinary team reviewed the resident's Medicare coverage status to ensure all future beneficiary notifications would be issued timely. 2. Identification of Other Residents Who May Be Affected The Administrator, MDS Coordinator, Licensed Social Worker or designee will conduct a retrospective audit of all Medicare Part A residents and recent Medicare discharges from the previous 60 days to verify: Required beneficiary notices were issued within CMS-required timeframes. Notices were provided to the resident and/or legal representative, when applicable. Documentation of delivery is complete within the		07/23/2026

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F0582 SS = D	Continued from page 5 facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R27) reviewed for beneficiary notices. Findings include: R27's quarterly Minimum Data Set (MDS) dated 3/12/26, indicated R27 had intact cognition. R27's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 2/15/26. R27's NOMNC form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 2/14/26. The form was signed by the resident dated 6/15/26. Additionally, R27's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 5/23/26. R27's NOMNC form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 5/23/26. The form was signed by the resident dated 6/15/26.			F0582	Continued from page 5 medical record. Copies of notices are maintained in accordance with facility policy. Appeal rights and required instructions were communicated appropriately. Any identified deficiencies will be corrected immediately through issuance of required notices when appropriate. 3. Systemic Changes to Prevent Recurrence The facility has reviewed its Medicare Beneficiary Notification Policy to ensure compliance with: Resident Rights Medicare Claims and Appeals requirements CMS Medicare beneficiary notification requirements Applicable Minnesota statutes and regulations governing long-term care operations. The following system improvements have been implemented: Responsibility for issuing required beneficiary notices has been clearly assigned to designated staff members. A secondary verification process has been implemented to confirm that required notices have been completed before Medicare-covered services end. MDS staff and Social Services personnel will receive education regarding: Required Medicare beneficiary notices.		07/23/2026

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F0582 SS = D	Continued from page 6 During an interview on 7/1/25 at 1:34 p.m., R27 stated she did not recall anyone reviewing the form mentioned above with her but was okay with her therapy services ending. During an interview on 6/17/26 at 9:28 a.m., administrator confirmed she oversaw reviewing NOMNCs with residents and, after reviewing R27's medical record, could not find evidence that the notice had been given to R27 at least two days before the end of Medicare Part A coverage as required. The facility's NOMNC policy dated 6/18/26 indicated the NOMNC must be delivered at least two calendar days before Medicare-covered services end.			F0582	Continued from page 6 CMS timeframes for notice delivery. Documentation requirements. Resident appeal rights. Minnesota requirements regarding resident notification and documentation. The Medicare meeting/process will include verification that all required beneficiary notices have been completed before coverage determinations are finalized. 4. Monitoring to Ensure Continued Compliance The Administrator or designee will conduct audits as follows: Weekly audits of all Medicare beneficiaries for four (4) consecutive weeks. Monthly audits thereafter for two (2) additional months. Audits will verify: Required beneficiary notices were issued timely. Required signatures or documentation of delivery are present. Notices are retained in the resident's medical record. Appeal rights were communicated appropriately. Staff followed the facility's beneficiary notification process.		07/23/2026

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F0582 SS = D				F0582	Continued from page 7 Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved. Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education. Completion date: July 23, 2026		07/23/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			F0656	Plan of Correction Deficiency: F0656 – Comprehensive Care Plans (Hospice Coordination & Smoking) 1. Corrective Action for Resident(s) Found Affected Resident 4 identified during the survey was immediately reviewed by the interdisciplinary team, including nursing, social services, therapy (as applicable), dietary, activities, and the hospice provider. Resident 4 comprehensive care plan was revised to accurately reflect hospice services, resident goals, interventions, and coordination of care between the facility and the hospice agency. Resident 1 identified during the survey was immediately reviewed by the interdisciplinary team, including nursing, social services, therapy (as applicable), dietary and activities. Resident 1 comprehensive care plan was revised to accurately reflect smoking status, resident goals and interventions. The resident and/or resident representative participated in the care planning process to ensure preferences and goals were incorporated into the comprehensive care plan. 2. Identification of Other Residents Who May Be Affected The Assistant Director of Nursing, MDS Coordinator, Licensed Social Worker or designee will conduct an audit of all current residents receiving hospice services and those who currently smoke to verify:		07/23/2026

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NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976			
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F0656 SS = D	Continued from page 8 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 3 resident (R4, R1) reviewed for hospice care and smoking. Findings Include: R4's quarterly Minimum Data Set (MDS) dated 5/12/26, indicated R4 was moderately cognitively impaired. R4's diagnosis included dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) with moderate agitation During record review on 6/16/26 at 10:01 a.m., noted R4 was admitted to hospice on 1/30/26. R4's comprehensive care plan failed to include a resident-specific hospice care plan, including hospice diagnosis, hospice provider information, and resident choices and preferences. During an interview on 6/16/26 at 1:24 p.m., registered nurse (RN)-A stated she is unsure why R4 was put on hospice, probably due to his infections or maybe his worsening dementia. RN-A stated she didn't know what end-of life preferences R4 had. During an interview on 6/16/26 at 1:27 p.m., Minimum Data Set (MDS)-A coordinator and RN-B stated after the resident chooses a hospice			F0656	Continued from page 8 A comprehensive care plan has been developed and implemented for all residents. Hospice services and interventions are accurately reflected in the facility care plans for all residents receiving hospice services. Responsibilities of both the facility and hospice provider are clearly identified in hospice care plans. Resident goals, preferences, and advance directives are incorporated into the care plans for all residents. Evidence of interdisciplinary participation and coordination with the hospice agency is documented for all residents receiving hospice services. Smoking status, goals and interventions are accurately reflected in the facility care plan for residents who have been assessed to smoke. Care plans have been reviewed and revised following significant changes in condition and at required intervals for all residents. Any identified deficiencies will be corrected immediately through interdisciplinary care plan review, collaboration with the hospice agency as applicable, and documentation updates. 3. Systemic Changes to Prevent Recurrence The facility has reviewed and revised its Comprehensive Care Planning, Smoking and Hospice Coordination policies to ensure compliance with: Comprehensive Person-Centered Care Planning Hospice Conditions of Participation, as applicable CMS Requirements of Participation for Long-Term Care Facilities		07/23/2026

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F0656 SS = D	Continued from page 9 company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident care plan and is updated to include pertinent hospice information. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. MDS-A confirmed R4 was admitted to hospice on 1/30/26. MDS-A confirmed R4's care plan did not have a hospice care plan. MDS-A and RN-B stated the hospice care plan is important, so all staff are aware of the resident status and how to care for him at the end-of-life stage. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan. R1 R1's quarterly Minimum Data Set (MDS) assessmen, dated 5/11/26, indicated intact cognition, and R1 was independent with mobility. R1's ecord review indicated R1's had impaired vision related to macular degeneration and was legally blind. R1 was able to ambulate up and down the halls in the facility and outside of the facility only in the area of the railing safely. Smoking observation/assessment dated 7/31/25 indicated, R1's was able to smoke independently, requested staff assistance when ready to go out to smoke and smoked less than a cigarette a day. R1's record review lacked smoking care plan (problem, goals/outcomes, and interventions). During an interview on 06/17/26 08:15 a.m., administrator acknowledged, R1 was able to smoke safely with staff assistance and had no smoking care plan in place. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan.			F0656	Continued from page 9 Applicable Minnesota statutes and regulations governing nursing facilities and hospice coordination. The following system improvements have been implemented: The Licensed Social Worker or designee will verify that hospice interventions are incorporated into the facility's comprehensive care plan within the required timeframe. The facility will ensure participation and documented communication between facility staff and hospice personnel during care conferences and interdisciplinary meetings. The Licensed Nursing Staff will verify that a smoking focused care plan is in place for all residents who elect to smoke. Licensed Nurses, MDS staff, and Social Services, will receive education regarding: CMS requirements for comprehensive person-centered care planning. Coordination of care between the nursing facility and hospice provider. Documentation requirements. Resident rights, goals, and preferences. Responsibilities outlined in hospice coordination agreements. 4. Monitoring to Ensure Continued Compliance The MDS Coordinator, or designee will complete audits as follows:		07/23/2026

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F0656 SS = D				F0656	Continued from page 10 Weekly audits of all residents receiving hospice services for four (4) consecutive weeks. Monthly audits thereafter for two (2) additional months. Ongoing, while completing MDS will ensure that a hospice care plan is in place for all residents identified as receiving hospice services. Ongoing, while completing MDS will ensure that a smoking care plan is in place for all residents identified as electing to smoke. Audits will verify: Comprehensive care plans accurately reflect hospice services and smoking status. Care plans include measurable resident-centered goals and appropriate interventions. Documentation demonstrates collaboration with the hospice provider. Required interdisciplinary participation is documented. Care plans are updated following significant changes in condition and within required regulatory timeframes. Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved. Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education.		07/23/2026

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F0656 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by:			F0656	Continued from page 11 Completion date: July 23, 2026		07/23/2026
F0676 SS = D				F0676	Plan of Correction Deficiency: F0676 – Activities of Daily Living (ADLs): Toileting 1. Corrective Action for Resident(s) Found Affected Resident 8 identified during the survey was immediately assessed by the interdisciplinary team to evaluate toileting needs, continence status, and the effectiveness of current interventions. The resident's care plan and nursing assistant care guide were reviewed and revised as needed to reflect individualized toileting assistance, scheduled toileting, prompted voiding, transfer assistance, continence products, and safety interventions. Staff will now be using a timer as a reminder to return to resident 8 room to prevent falling asleep on the toilet. Licensed nursing staff educated direct care staff on the resident's individualized toileting plan. The resident and/or resident representative were informed of any changes to the plan of care, and documentation was completed in the medical record. 2. Identification of Other Residents Who May Be Affected The Assistant Director of Nursing, or designee will conduct an audit of all residents requiring toileting assistance to verify: The comprehensive care plan accurately reflects individualized toileting needs and interventions. Nursing assistant assignment sheets and care guides reflect the current toileting plan. Scheduled toileting or prompted voiding programs are implemented as ordered or care planned. Staff documentation demonstrates toileting assistance is provided according to the resident's assessed needs.		07/23/2026

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F0676 SS = D	Continued from page 12 Based on observation, interview, and document review, the facility failed to provide supervision to 1of 1 resident (R8) reviewed for activities of daily living who was left unattended on the toilet for more than 1 hour. Findings Include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living and maximal assistance with mobility. R8 's care plan dated 5/4/26 indicated, resident had a history of falling related to impulsiveness and perceived abilities. Motion sensor alarm to monitor movements due to unattended / unassisted transfers resulting in falls, reminders to use call light for all transfers. Record review indicated R8's had an unwitnessed fall on 6/12/26 at 10:06 a.m., in the bathroom, right beside the toilet and the wheelchair. R8's head was found leaning against the corner of the doorway. During an observation on 6/16/26 9:03 AM, R8 was assisted onto the toilet by nursing assistant (NA)-A. At 9:40 a.m., R8 was observed sitting on the toilet, chin to chest, sleeping and snoring lightly. At 10:10 a.m., staff returned to R8's bathroom and assisted R8 off the toilet, then to bed. During an interview on 6/16/26 2:21 p.m., nursing assistant (NA)-A stated, R8 was able to use the call light when ready, R8 had requested more time on the toilet when staff had gone too early in the past. When asked to clarify the meaning of too early, NA-A stated, 10 to 15 minutes. When pointed out to NA-A, R8 had fallen asleep on the toilet, NA-A stated, yes, R8 liked to sleep on the toilet. NA-A stated, today was busy or I would have gone back in there sooner. During an interview 6/18/26 11:04 a.m., assistant director of nursing (ADON) stated, the expectation was for staff to check in with residents at least 15 minutes when left unattended on the toilet.			F0676	Continued from page 12 Residents are receiving assistance that promotes dignity, comfort, continence, and the highest practicable level of independence. Any deficiencies identified during the audit will be corrected immediately through reassessment, care plan revisions, staff education, and implementation of appropriate interventions. 3. Systemic Changes to Prevent Recurrence The facility has reviewed its Activities of Daily Living (ADL) policy to ensure compliance with: Quality of Life (Activities of Daily Living) CMS Requirements of Participation for Long-Term Care Facilities Applicable Minnesota statutes and regulations governing resident care and nursing services. The following systemic improvements have been implemented: Residents will receive a comprehensive continence and toileting assessment upon admission, quarterly, following a significant change in condition, and whenever changes in continence or functional status are identified. Individualized toileting schedules, prompted voiding programs, and continence interventions will be developed based on each resident's assessed needs and incorporated into the comprehensive care plan. Nursing assistant care guides and assignment sheets will be updated promptly following any changes in toileting needs. Licensed nurses and nursing assistants will receive education regarding: Resident rights and dignity during toileting		07/23/2026

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F0676 SS = D	Continued from page 13 Facility policy titled “Activity of Daily Living (ADL) Assistance and Functional Maintenance reviewed on 6/18/26 indicated, provide supervision and support to residents with balance deficit or fall risks.			F0676	Continued from page 13 assistance. Timely response to requests for toileting assistance. Scheduled toileting and prompted voiding techniques. Documentation expectations. Recognition and reporting of changes in continence status. Nursing leadership will reinforce compliance with individualized toileting programs during daily clinical rounds and shift reports. 4. Monitoring to Ensure Continued Compliance Assistant Director of Nursing, or designee will conduct compliance audits as follows: Ten (10) residents requiring toileting assistance will be audited weekly for four (4) consecutive weeks. Thereafter, ten (10) residents will be audited monthly for two (2) additional months. Audits will verify: Toileting assistance is provided according to the resident's individualized care plan. Scheduled toileting and prompted voiding programs are implemented consistently. Nursing assistant documentation is complete and accurate. Care plans and nursing assistant care guides remain current.		07/23/2026

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F0676 SS = D				F0676	Continued from page 14 Residents are assisted in a manner that promotes dignity, privacy, comfort, continence, and the highest practicable level of independence. Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved. Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education. Completion date: July 23, 2026		07/23/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete weekly wound assessment and documentation for 1 of 1 resident (R6) reviewed for pressure Ulcer/Injury who had 2 unhealed stage 4 pressure ulcers (full-thickness skin and tissue loss, exposed bone, ligament, cartilage, or muscle) on bilateral buttocks. This had the potential to delay identification of changes in wound status and impact timely interventions to promote			F0686	Plan of Correction Deficiency: F0686 – Treatment/Services to Prevent and Heal Pressure Ulcers/Injuries (Wound Assessments and Measurements) 1. Corrective Action for Resident(s) Found Affected Resident 6 identified during the survey received an immediate comprehensive wound assessment by the licensed nurse and/or wound care nurse. Wound measurements, including length, width, depth (when applicable), tunneling, undermining, wound bed characteristics, drainage, and periwound condition, were completed and documented in the medical record using the facility's standardized wound assessment process. Most recent measurements were documented July 17, 2026. The attending physician and wound care provider were notified as appropriate, and treatment orders were reviewed to ensure they reflected the resident's current wound status. The comprehensive care plan was updated to include individualized interventions, monitoring, and treatment goals based on the current wound assessment. 2. Identification of Other Residents Who May Be Affected The Assistant Director of Nursing or designee will		07/23/2026

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F0686 SS = D	Continued from page 15 healing. Findings Include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/3/26, identified R6 had intact cognition and was dependent on staff for activities of daily living and mobility. MDS identified two stage 4 pressure ulcers, pressure reducing device for bed, chair and application of nonsurgical dressing and ointment. R6's diagnoses included stage 4 pressure on right and left buttock, hereditary spastic paraplegia (inherited disorders that cause progressive stiffness and weakness in the legs, often leading to mobility challenges). R6's care plan dated 6/10/26, directed staff to assess the pressure ulcer location, stage, size (length, width and depth), presence/ absence of granulation (healing) tissues, conduct a systematic skin inspection weekly and report any signs of further skin breakdown. R 6's wound treatment order dated 4/14/26 included: dressing plan for the bilateral open stage 4 ischial pressure injuries, continue to use Vashe (wound cleanser) barely moistened kerlix covered with ABD (thick multi-layered medical dressing) pad held in place with silicone tape, 3 times daily. R6's Electronic Medical Record (EMR) review indicated R6 was hospitalized from 1/16/26 to 01/26/26 for progressive worsening of bilateral buttocks stage 4 pressure ulcers with concern for infection and a hospitalization from 05/14/26 to 5/18/26 for acute osteomyelitis (infection in a bone), both ischial (sit bones) wounds were open to bone and periosteum (connective tissues), with the left wound correlating with new osteomyelitis. Review of R6's EMR wound documentation identified 3 wound assessments and documentation in 90 days: On 3/31/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. bottom looked good overall with scant amount of maceration to peri wound. Left buttock wound measured; 4 cm(centimeters) L(length) x 7 cm W(width)x 7 cm D (depth),Right gluteal wound measuring 2 cm (L) x 3.5 cm (W) x 5.3 cm (D). On 04/2/26, wound documentation indicated: old			F0686	Continued from page 15 conduct an audit of all residents with pressure injuries to verify: Comprehensive wound assessments are completed at the frequency ordered by the physician and in accordance with facility policy. Wound measurements are complete, accurate, and consistently documented. Changes in wound condition are identified and communicated to the physician as appropriate. Treatment orders are current and consistent with the wound assessment. The resident's comprehensive care plan reflects current wound status and interventions. Any deficiencies identified during the audit will be corrected immediately through reassessment, documentation updates, physician notification when indicated, treatment revisions, and care plan updates. 3. Systemic Changes to Prevent Recurrence The facility has reviewed its Skin Integrity and Wound Management policies to ensure compliance with: CMS Requirements of Participation for Long-Term Care Facilities National standards of wound care practice Applicable Minnesota statutes and regulations governing nursing services and clinical documentation. The following systemic improvements have been implemented: A standardized wound assessment form will be used		07/23/2026

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F0686 SS = D	Continued from page 16 dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. Left buttock wound measured; 9.6 cm (L) x 5.2 cm (W) x 9.2 cm (D), Right gluteal wound measuring 3.5 cm (L) x 2.7 cm (W) x 5.0 cm (D). On 6/3/26, wound documentation current indicated: wound care completed this AM after resident had a shower. Left buttock wound measured 1.5cm x 2.0 cmx 4.0cm Right buttock wound measured 2.0 cm x 4.0 cm x 6.4.cm, no s/s of infection, no odor, no drainage, resident denies pain and tolerated treatment well. During an observation and interview on 6/17/2026 7:22 a.m., R6 stated, wounds dressing changes were completed by 7 a.m., between 12 p.m., and 2:00 p.m., and after 7:00 p.m., R6 said he spent most of the day in the facility apartment visiting his wife and returned to the facility for medications and treatments. During observation on 6/17/2026 1:40 p.m. R6 returned to the facility, took scheduled medications, declined wound treatment and assessment, and returned to the facility apartment to visit his wife. During an interview on 06/17/26 12:50 p.m., licensed practical nurse, (LPN)-A stated, weekly wound assessment and documentation was completed by the nurse manager. During an interview on 06/17/26 10:57 a.m., interim director of nursing (IDON) stated, the expectation was all wounds would be measured and documented on weekly basis. During an interview on 06/17/26 at 2:33 p.m., licensed nurse practitioner (NP)-B expected facility staff to complete weekly wound assessment and report any issues identified. Facility policy title "Skin Integrity, Wound, Care and Pressure Injury Prevention" reviewed on 6/18/26 on indicated, all wound, and pressure injuries shall be assessed upon identification and monitored routinely thereafter. Assessment shall include Location, size and measurement, stage (if applicable), appearance of wound bed, drainage characteristics, sign and symptoms of infections, pain, periwound condition and response to treatment. Residents with existing			F0686	Continued from page 16 for every wound evaluation to ensure consistent documentation of: Length, width, and depth using consistent measurement techniques. Tunneling and undermining, when present. Wound bed tissue characteristics. Drainage amount and type. Wound edges and periwound skin condition. Signs and symptoms of infection. Resident response to treatment. Licensed nurses responsible for wound care will receive education regarding: Proper wound measurement techniques using standardized methods. Accurate and objective wound documentation. Frequency of wound assessments. Physician notification requirements for changes in wound condition. Documentation requirements under CMS and Minnesota regulations. The Assistant Director of Nursing or designee will review weekly wound documentation for completeness and accuracy prior to interdisciplinary wound rounds. Interdisciplinary wound rounds will continue on a routine schedule to monitor healing progress, review		07/23/2026

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F0686 SS = D	Continued from page 17 wounds or pressure injuries shall have treatment goals and interventions reflected in the care plan.			F0686	Continued from page 17 treatment effectiveness, and revise interventions as needed. 4. Monitoring to Ensure Continued Compliance The Assistant Director of Nursing or designee will conduct compliance audits as follows: Weekly audits of all residents with pressure ulcers for four (4) consecutive weeks. Monthly audits thereafter for two (2) additional months. Audits will verify: Wounds are measured using a consistent standardized method. Measurements are complete, accurate, and documented timely. Comprehensive wound assessments are completed according to physician orders and facility policy. Physician notification occurs when significant changes in wound status are identified. Treatment orders and care plans reflect the resident's current wound condition. Documentation supports ongoing evaluation of wound healing. Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved.		07/23/2026

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F0686 SS = D				F0686	Continued from page 18 Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education. Completion date: July 23, 2026		07/23/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R37) reviewed for pharmacy services. Findings include:			F0755	Plan of Correction Deficiency: F0755 – Pharmacy Services/Medication Availability and Labeling Related Concern: Medications Not Available, Failure to Document Medication Unavailability, and Failure to Take Timely Action 1. Corrective Action for Resident(s) Found Affected Resident 37 identified during the survey was immediately reviewed by the Assistant Director of Nursing (ADON) and/or designee to determine whether any medications were unavailable and whether appropriate actions were taken to prevent missed or delayed doses. For any identified medication availability concerns, the facility immediately: Contacted the pharmacy to obtain the unavailable medication or determine the cause of the delay. Obtained emergency supply medications when indicated. Notified the prescribing provider of missed, delayed, or unavailable medications when clinically indicated. Assessed the resident for any adverse effects related to delayed or missed medication administration. Completed required documentation in the medical record, including the reason the medication was unavailable and the actions taken to obtain the medication and prevent recurrence. The resident's care plan was reviewed and updated as appropriate to reflect medication management needs.		07/23/2026

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F0755 SS = D	Continued from page 19 R37 face sheet indicated R37 admitted to the facility on 6/3/26. R37's admission Minimum Data Set (MDS) assessment, dated 6/9/26, indicated R37 was cognitively intact with no delirium and no behaviors. R37 had upper and lower body impairment and required assistance with all activities of daily living. The MDS also indicated R37 had diagnoses of anxiety and depression. R37's diagnoses list included heart disease, major depressive disorder, and generalized anxiety disorder. R37's care plan indicated R37 received an antianxiety medication related to anxiety disorder. R37's hospital discharge orders dated 6/3/26, indicated clonazepam (prescribed to treat anxiety)0.5 mg tablet give 1/2 tablet twice a day R37's Medication Administration Record (MAR) indicated R37 had an order for clonazepam 0.5 mg tablet. Give 1/2 tablet twice a day scheduled. The MAR further indicated R37 did not receive the clonazepam from 6/3/26 evening shift through 6/15/26 due to "drug not available." Additional notes on the MAR indicated on 6/3/26 "drug unavailable, resident informed. Will call pharmacy in the AM". On 6/5/26 evening shift the MAR also indicated "medication not found, also checked Ekit (emergency kit) not available". On 6/11/26 the MAR also indicated "no written script from pharm"(pharmacy). R37's progress notes indicated R37 was seen on 6/4/26 for a first post admission recertification with orders for labs placed. The progress notes also indicated R37 was seen at the facility by the nurse practitioner for an acute visit on 6/10/26. The progress notes lacked documentation a provider was updated of R37's clonazepam not being administered due to being unavailable. A hand written faxed document dated 6/4/26, to the medical director indicated "FYI. [facility pharmacy] needs an updated script for [R37] clonazepam." Provider progress notes indicate the medical director was in the facility on 6/4/26 to sign R37's admission orders and R37 was seen for an acute visit on 6/10/26. Neither document mentioned needing a valid prescription for clonazepam. During an interview on 6/16/26 at 11:21 a.m., trained			F0755	Continued from page 19 2. Identification of Other Residents Who May Be Affected The Assistant Director of Nursing or designee will conduct a retrospective audit of medication administration records and pharmacy communication documentation for all current residents for the previous 30 days to identify: Any medications that were unavailable at the time of administration. Whether the medication omission or delay was appropriately documented. Whether nursing staff took timely action to obtain the medication. Whether the provider and pharmacy were notified when appropriate. Whether follow-up actions were documented. Any identified concerns will be corrected immediately through appropriate pharmacy follow-up, provider notification, clinical assessment, and staff education. 3. Systemic Changes to Prevent Recurrence The facility has reviewed and revised its Medication Management and Pharmacy Services policies to ensure compliance with: Pharmacy Services Quality of Care CMS Requirements of Participation for Long-Term Care Facilities Applicable Minnesota Board of Nursing standards and Minnesota Department of Health requirements		07/23/2026

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F0755 SS = D	Continued from page 20 medication aide (TMA)-A stated if a medication was not found, she would look through all of the medication carts and call the pharmacy to order it. TMA-A stated staff "are not supposed to" document "unavailable" on the MAR. If a script is needed, she would tell the nurse on duty. When asked about R37's clonazepam, TMA-A stated "I think they were trying to get her off of that, I'm not really sure. I know it wasn't a prior authorization thing.". TMA-A looked through the medication cart and verified there was no card of clonazepam available. During an interview on 6/16/26 at 1:01 p.m., the pharmacy technician stated the pharmacy last filled 30 tablets of clonazepam for R37 on 11/6/25 and they do not have a current order for clonazepam for R37. During an interview on 6/16/26 at 1:08 p.m., licensed practical nurse (LPN)-A stated if a medication is not available the pharmacy is notified and a note is made in the progress notes. If the pharmacy states a new script is required, the provider is updated. LPN-A stated he does not work with R37 often but does recall one of the nurses stating messages were sent to the provider for the clonazepam order. LPN-A reviewed R37's progress notes and confirmed there is no documentation stating a provider was updated. LPN-A stated an SBAR (a note written to providers) is placed in the SBAR binder. LPN-A could not find documentation in the binder indicating a request for clonazepam was made. On 6/16/26 at 2:08 p.m., the administrator provided an SBAR that was written on 6/14/26 to the provider indicating "discontinue orders for Clonazepam BID. No script, has not taken while here". During interview on 6/16/26 at 2:21 p.m., the nurse practitioner (NP) stated she is at the facility weekly. The NP confirmed R37 was discharged from the hospital with an order for clonazepam 0.5 mg tablet 1/2 tablet twice a day. The NP also confirmed R37 was seen by the medical director on 6/4/26 and by her on 6/10/26 for an acute visit. The NP stated she was unaware R37 had not been receiving clonazepam and did not see any documentation or fax indicating a request for a script for clonazepam. The NP stated she would expect to be notified immediately if a medication was unavailable. During an interview on 6/17/26 at 8:18 a.m., the assistant director of nursing (ADON) stated the facility has a binder with the procedure for obtaining medications that are controlled substances. The			F0755	Continued from page 20 related to medication administration and resident safety. The following systemic improvements have been implemented: Licensed nurses and trained medication aides (TMA) will be educated regarding expectations when medications are unavailable, including: Immediate notification of the pharmacy when medications are not available. Assessment of the clinical impact of a missed or delayed medication. Notification of the provider when indicated. Documentation of the unavailable medication and all interventions taken. Continued follow-up until the medication is obtained and available for administration. A standardized Medication Unavailable Documentation process has been implemented to require documentation of: Medication name and dose. Date/time medication was unavailable. Reason medication was unavailable. Pharmacy notification and response. Provider notification, if applicable. Actions taken to obtain medication. Outcome/resolution.		07/23/2026

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F0755 SS = D	Continued from page 21 ADON stated if a medication is unavailable, staff are expected to check the emergency kit, reach out to the pharmacy, and reach out to the provider. The ADON stated she expects continued communication until the medication is available. The ADON confirmed the documentation the medication was not available. She stated she would expect the nursing staff to communicate with the providers at least every shift until the situation was rectified. The ADON confirmed the medical director was at the facility on 6/4/26 to certify R37's admission orders and the nurse practitioner saw R37 on 6/10/26 for an acute visit. The ADON confirmed there was no evidence a provider was notified of the clonazepam between the fax on 6/4/26 and the SBAR written 6/14/26. She stated the facility had ample opportunity to reach out to the providers to obtain the script for the clonazepam. A policy titled "Procedure for Addressing Controlled Substance/Narcotic Supply shortage" dated 11/5/25, indicated if it is a med we have in the emergency kit, first call the pharmacy (after hour pharmacy if that is appropriate) to see if you can access the emergency kit for the medication, if they say yes, do so and document/request replacement accordingly. But you will need to send a request for a refill if the pharmacy is not planning on sending more to the facility. If no, because there is not a valid Rx [prescription], then you will have to call the provider or the on-call provider for after hours. If they do it, ask them to be sure to send it to [pharmacy name]. It is then necessary to document what you have done and what the result is. If for some reason you are not able to get a medication, you need to monitor the resident, offer non-pharmacological interventions, and if that is not enough, call the family to notify and send the resident to the ED (emergency department). Notify facility DON by phone or email.			F0755	Continued from page 21 A new policy titled, "Medication Not Immediately Available" to guide staff through the process. Nursing leadership will review medication availability concerns during daily clinical meetings to ensure timely resolution. The facility will collaborate with the contracted pharmacy provider to review medication delivery processes, emergency medication availability, and communication expectations. Medication carts and medication availability will be monitored routinely to identify potential supply issues before medications are due. 4. Monitoring to Ensure Continued Compliance The Assistant Director of Nursing, or designee will complete audits as follows: Audit medication administration records for residents with unavailable medications weekly for four (4) consecutive weeks. Monthly audits thereafter for two (2) additional months. Audits will verify: Medications are available and accessible for administration as ordered. Unavailable medications are identified promptly. Appropriate documentation is completed. Pharmacy and provider notifications occur when required. Timely corrective actions are initiated and resolved.		07/23/2026

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F0755 SS = D				F0755	Continued from page 22 Missed or delayed medications are reviewed for potential resident impact. Audit results will be reviewed by the Facility Administrator. Any trends, identified deficiencies, or opportunities for improvement will result in additional education, policy review, and corrective action. Audit results will be presented to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Monitoring will continue as needed until the QAPI Committee determines sustained compliance has been achieved. Education for this plan of correction will be presented immediately following submission and will be ongoing until all appropriate staff have received the education. Completion date: July 23, 2026		07/23/2026