Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 5, 2025

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: April 3, 2025

Dear Administrator:

On June 2, 2025, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
April 28, 2025

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, 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 July 3, 2025 (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 October 3, 2025 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 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
F 000	INITIAL COMMENTS On 3/31/24-4/3/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53496789C (MN00105595). The following complaints were reviewed. Deficient practice was identified related to incidental finding H53491761C (MN00111622) H53491262C (MN00109968) H53491263C (MN00109966) H53491288C (MN00109965) H53491285C (MN00109967) H53491286C (MN00109963) H53492284C (MN00109930) 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 has been attained.	F 000		
F 692	Nutrition/Hydration Status Maintenance	F 692		5/16/25

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

Electronically Signed | 05/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 692 SS=D	Continued From page 1 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R6) reviewed for nutrition and weight loss had received a supplement to increase calorie intake and weight per provider order. Findings include: R6's face sheet included diagnoses of history of traumatic brain injury, weakness, pain, surgery of the digestive system, vascular disorder of the intestine, ischemic colitis (reduced blood flow to the colon), intestinal obstruction, and dysphagia (difficulty swallowing foods and liquids).	F 692	Regulation 483.25(g)(1)-(3) Tag F692 Nutrition/Hydration Status Maintenance This plan of correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center ensures that	

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F 692	Continued From page 2 R6's significant change Minimum Data Set (MDS) assessment dated 1/21/25, indicated moderately impaired cognition, no behaviors or rejection of care, use of a wheelchair, substantial/maximal assistance with toileting hygiene, bathing, dressing, and personal hygiene. R6's care plan revised 1/31/25, indicated history and risk of dehydration, thickened liquids, risk for aspiration related to traumatic brain injury and postural positioning, poor safety awareness related to eating, pureed diet, and approaches of encouraging R6 to follow diet orders, eat small bites, chew well, eat smaller meals frequently throughout the day, and monitor for signs and symptoms of aspiration. R6's care plan further indicated R6 was able to feed himself after setup assistance, had a history of difficulty swallowing, and refused assistance with tasks beyond setup. R6's care plan category: nutritional assessment updated 1/31/25, indicated R6 was hospitalized from 12/11/24-12/20/24, due to intestinal obstruction and aspiration pneumonia. Diet was ordered for puree texture foods and thickened liquids. Video swallow completed 12/26/24, R6 and family chose to have no enteral feeding. Supervision and aspiration precautions to be observed. R6 height 72 inches and weight 145.6 pounds. Weight one month ago 161.8 pounds, weight 6 months ago 163.4 pounds. Weight loss of 9.7% in one month and 10.8% in 6 months. Weight loss related to swallow problem and due to need for hospitalization with surgical procedure. Will continue to provide food/fluid for comfort. Review of R6's record on 4/1/25, indicated the	F 692	based on a resident's comprehensive assessment, the facility assists the resident in maintaining an acceptable parameter of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible, or the resident preferences indicate otherwise. The facility provides 1) nutritional and hydration care and services to each resident, consistent with the residents comprehensive assessment 2) recognizes, evaluates, and addresses the dietary needs of every resident, including residents at risk or already experiencing impaired nutrition and hydration and 3) when there is a nutritional indication, a therapeutic diet that takes into account the residents clinical condition and preferences. A comprehensive nutritional assessment is completed on all residents to identify those being at risk for unplanned weight changes and/or compromised nutritional status. The interdisciplinary care team considers the residents overall condition and clarifies nutritional issues and needs. The assessment identifies factors that place the resident at risk for inadequate nutrition/hydration and considers the residents height, weight and medical diagnoses. The medical provider and/or consultant dietitian is notified when there is significant weight loss or other nutritional/dietary issues of concern. The	

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F 692	Continued From page 3 following weights: 10/1/24- 160.3 pounds 11/1/24- 156.4 pounds 12/1/24- 161.4 pounds 1/2/25- 145.8 pounds 2/2/25- 139.6 pounds 3/1/25- 134.6 pounds 4/1/25- 135 pounds Review of R6's nutritional assessment dated 2/20/25 indicated registered dietician (RD) documented weight loss of 11% in six months. RD requested nutritional supplement eight ounces three times per day with meals, staff assist as needed. R6's physician's orders printed 4/1/25, indicated dysphagia diet, pureed texture. R6's physician's orders did not include an order for a nutritional supplement due to weight loss. Review of a facility provided document titled Physician's Telephone Order dated 3/1/25, indicated a physician's order for Ensure/Boost supplement eight ounces three times per day with meals due to weight loss was ordered on 3/1/25. During interview on 4/2/25 at 11:39 a.m., RD stated she reviewed R6's record on 2/20/25, and recommended a supplement three times per day due to weight loss. RD stated R6's height was 72 inches tall and she would expect him to increase his weight to 178 pounds. RD further stated extra calories were needed to increase his weight back to baseline. RD stated she was not aware the supplement had not been started and would have expected it to be put in within one week of her recommendation.	F 692	residents and family are encouraged to share food preferences, lifelong dietary practices and goals of care. A nutrition plan of care addressing nutritional risk factors is drafted for each resident and is communicated to the staff. The facility has a policy for accurate and timely processing of physician orders and consultant dietitian recommendations. The facility policy, Nutritional Supplements, was reviewed and updated to include directions for transcribing nutritional supplement orders and communicating the orders to the nursing and dietary staff. The licensed nursing staff will be reinstructed on the policy and related procedures, including the processing and transcribing of orders for nutritional supplements. Resident number 6 was noted to have difficulty swallowing due to a traumatic brain injury with a history of aspiration. The resident was receiving a dysphagia diet with pureed foods and had ongoing weight loss despite nutritional/dietary interventions by the staff. Due to continued weight loss, a nutritional dietary supplement was recommended by the consultant dietitian. The supplement was started April 1, 2025, immediately after the issue of the missing order transcription was brought to the facility's attention. Resident number 6 will be weighed weekly rather than monthly to facilitate closer tracking of weight changes. The resident has had a weight gain of 1 pound and 10 ounces in the past 60 days. The	

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F 692	Continued From page 4 During interview on 4/2/25 at 11:58 a.m., director of nursing (DON) stated she was not aware R6's order for nutritional supplement had not been entered. DON stated any nurse could put orders in, but they didn't have a good system, and this order had been placed on her desk and lost in a stack of papers. DON further stated she would expect this order to be entered within one to two days of being signed by the provider. A policy on order entry of nutritional supplements was requested but not received.	F 692	medical provider and/or consultant dietitian will be notified of weight changes of concern. The residents care plan was reviewed and updated. Compliance will be monitored by the Director of Nursing/designee. The consultants written recommendations which are provided to the facility after each monthly visit will be reviewed by the Director of Nursing/designee for four months. If there are recommendations for dietary supplements, the physicians orders will be reviewed to ensure the recommendation was communicated to the physician and resultant orders are listed in the electronic medication administration record. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the June 2025 quarterly Quality Assurance and Performance Improvement Committee meeting. Date of Completion: May 16, 2025	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		5/16/25

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F 761	Continued From page 5 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure discontinued medications were returned to the pharmacy or destroyed in a timely manner to decrease the potential for drug diversion for 1 of 1 medication rooms. Findings include: During an observation and interview with Licensed Practical Nurse (LPN)-A on 4/2/25 at 11:00 a.m., the shelf in the medication room had 108 cards of varying oral medications including blood pressure medications, supplements, antidepressants, etc. There were also two plastic bins with varying creams, bulk powdered medications, bottled liquid medications, boxes of insulin pens, and IV (intravenous) antibiotic medications. These medications included: -One unopened box of 5 glargine insulin pens	F 761	Regulation 483.45(g)(h)(1)(2) Tag F761 Label/Store Drugs and Biologicals This plan of correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center provides pharmaceutical services to meet the needs of each resident. The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	

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F 761	Continued From page 6 dated 12/8/24 and an unopened box of 5 aspart insulin pens dated 1/2/24 for R39. -Ten medicine balls of intravenous cefazolin (antibiotic) dated 1/13/25 for R92, two unopened bottles of liquid Haldol (antipsychotic medication used to treat mental health disorders) containing 15 ml (milliliters) and 30 ml's liquid medication dated 3/4/25 for R93. -an undated, unlabeled bottle of Haldol containing 12 ml's liquid medication. -Two full boxes of sodium polystyrene (liquid medication used to treat elevated potassium) dated 2/15/25 for R7. LPN-A stated the medications on the shelf either needed to be sent back to the pharmacy or destroyed. Medications that need to be sent back to the pharmacy are placed in brown paper bags and sent with the pharmacy delivery driver who comes daily. LPN-A stated all shifts are responsible for helping destroy or prepare medications that need to be sent back. LPN-A confirmed the amounts of medications. R39's record read passed away on 1/29/2025. R93's record read passed away on 3/5/2025. R92's provider orders indicated cefazolin was ordered every 12 hours x 6 days with an end date of 1/21/2025. R92's face sheet indicated an admission date of 1/6/2025 and a discharge date of 3/14/2025. R7's provider order indicated sodium polystyrene was discontinued 2/26/2025. During interview on 4/2/25 at 11:33 a.m., the infection preventionist/assistant director of nursing (IP) confirmed the medications on the counter are due to be sent back or destroyed and	F 761	instructions, and the expiration date when applicable. All drugs and biologicals are stored in temperature controlled secure areas where only authorized staff have access. Controlled drugs and biologicals are maintained under an additional secondary form of security. The policy “Discontinued Medications” has been archived, and new policies have been implemented specifically addressing 1) medications that are returned to the pharmacy 2) medications that are returned to the resident upon discharge and 3) medications that are destroyed/discarded due to order changes or expiration dates. Outdated and expired drugs and biologicals will be discarded according to accepted practice standards. The licensed nursing staff and the trained medication aides will be instructed on the new policies. All medication storage areas have been checked for expired medications and biologicals as well as medications/biologicals belonging to residents who have been discharged from the facility. A staff member will be assigned to routinely monitor the medication rooms to ensure that medications and biologicals which are expired, outdated, or ordered for residents no longer at the facility are processed in a timely manner. The inactive medications ordered for residents’ numbers 7, 39, 92 and 93 have been discarded. Once instruction is completed, the	

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F 761	Continued From page 7 are from residents who have been discharged, passed away, or had orders changed. The IP confirmed R93 passed away, R92 discharged, R7's orders changed to a different form of the medication, R39 passed away. During interview on 4/3/25 at 10:46 a.m., the consultant pharmacist (CP) stated residents receiving Medicare-A benefits get reimbursed and should have their medications returned to the pharmacy. Others should be returned for destructions or can be destroyed at the facility. Medications due to be credited should be returned to the pharmacy within 30 days, the remaining medications should be destroyed as soon as possible. CP indicated the monthly bubble pack medications are usually returned to the pharmacy, however, the staff could destroy them at the facility. During an observation and interview on 4/3/25 at 10:52 a.m., the administrator stated medications no longer needed are pulled from the medication cart and placed in the med room waiting to be sent to the pharmacy or destroyed. The administrator stated very little medications get sent back and nurses destroy them "when they have time". The administrator stated she would expect medications to be destroyed or sent back biweekly and all nurses are expected to make sure medications get destroyed timely. Administrator observed the medications stored on the counter and confirmed the medications should have been taken care of to decrease the risk of diversion. During an interview on 4/3/25 at 11:52 a.m., the director of nursing stated destruction of medications is time dependent, however would	F 761	licensed nursing staff and the trained medication aides will monitor the medication storage areas for expired/inactive medications and biologicals on an ongoing basis as part of their daily work duties. To further monitor compliance, the medication storage areas will be checked by the Director of Nursing/designee for expired medications and biologicals every two weeks for three months. The Consultant Pharmacist will be asked to conduct random observations of medication storage areas checking for expired/inactive medications and biologicals. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the June 2025 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion Date: May 16, 2025	

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F 761	Continued From page 8 "hopefully be done within a month". Staff education provided to nursing staff January 2025 indicated "Returns are all nurses jobs on all shifts!!!. If you have downtime do them! It should not take hours for one person to do them after they get ignored and piled up!!" It continues, "These are just some things that have been seen while doing cart audits that will help keep our medication carts/med storage at state regulations.' A policy dated 12/01/2016 titled "Discontinued Medications" indicated, discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies. Complete 'Destruction of non-control substances' form and dispose of medications"	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served warm/hot and palatable to promote quality of life and nutritional intake for 2 of 2 residents (R16 and R29) reviewed for dining. This had the potential to affect all residents who received food	F 804	Regulation 483.60(i)(1)(2) Tag F804 Nutritive Value Appearance, Palatable/Preferred Temperature of Food and Drink This plan of correction constitutes a	5/16/25

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F 804	Continued From page 9 from the kitchen. Findings include: During an observation on 4/02/25 at 7:07 a.m., the cook (C)-A was preparing breakfast, food observed on the heat table included oatmeal, malt-o-meal, ham, and western style eggs. Toast was sitting above the steam table on a metal baking sheet. 4/02/25 at 7:34 a.m., plating begins for the residents seated in the dining room, C-A stated meals are served to dining room first then resident who prefer a tray in their rooms. 4/2/25 at 8:15 a.m., plating begins for East wing, trays put inside transport cart and delivered, last tray delivered to R16 in the East wing 4/2/25 at 8:22 a.m. 4/2/25 at 8:36 a.m., plating begins for North wing, trays put inside transport cart and delivered. 4/2/25 at 8:47 a.m., plating begins for West wing; extra tray added to transport cart for tasting. Last tray delivered to R29 on 4/2/25 at 9:03 a.m. 4/2/25 9:05 a.m., extra tray taken back to kitchen, C-A and dietary aide (DA)-A tasted meal on extra tray. C-A and DA-A confirmed eggs, and ham were cold and the toast was cold and soggy. C-A confirmed the toast was cooked at 7:07 a.m. was the same batch served to the last resident at 9:03 a.m. During interview on 4/2/25 at 9:33 a.m., R29 was observed to be the last resident to get her meal tray delivered to her room, she stated her eggs	F 804	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center prepares meals for the residents by methods that conserve nutritive value, flavor, and the staff provides food and drink that are palatable, attractive, and at a safe and appetizing temperature. The staff recognizes that 1) providing palatable, attractive, and appetizing food and drink can help to encourage residents to increase the amount they eat and drink and 2) improved nutrition and hydration status can help prevent, or aid in recovery from, illness or injury. The procedures for delivering meal trays to residents who prefer to eat in their room were reviewed. Dietary and nursing staff have been reminded of the need to deliver meals to the room as soon as possible after preparation. A system has been implemented to ensure timely communication between dietary and nursing staff regarding final tray preparation time and tray availability to the resident care wings. To shorten the time food trays, remain in the delivery cart, trays will be delivered one unit at a time. The temperature on the plate warmer has been increased to help maintain an appropriate food serving temperature.	

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F 804	Continued From page 10 were cold, the toast was soggy, and the ham was a little chewy and cold. She stated she did not eat much of it; observed resident tray to be approximately 1/4 of portion was eaten. During interview on 4/2/25 at 10:38 a.m., R16 was observed to be the last resident to get his tray in the east wing. He stated his breakfast delivered this morning on 4/2/25 at approximately 8:20 a.m., the toast was so soggy he couldn't even eat it. The ham and eggs were both cold, so he did not eat any of it; observed resident tray to be uneaten. During interview on 4/3/25 at 11:45 a.m., C-A confirmed the breakfast foods can be difficult to keep warm or hot. C-A confirmed toast left sitting for over two hours would be expected to be soggy and cold; should have been redone. During interview on 4/3/25 at 11:45 a.m., dietary manager (DM) confirmed toast left out for 2 hours should not have been served to residents. Facility policy dated 2/2023 stated safe food handling procedures for time and temperature control will be practiced in the transportation and delivery of all food items.	F 804	All residents will continue to be asked about their satisfaction with culinary services during their quarterly care conference. Resident number 16 and one random resident who dines in his/her room will be interviewed by the Social Worker/designee every two weeks for one month regarding their satisfaction with food services. Resident number 29 has been discharged from the facility. Any concerns will be reported to the interdisciplinary team. To monitor compliance, the dietary manager/designee will check the temperature of food leaving the kitchen and again at the point of delivery to two random resident rooms twice weekly for one month. Temperatures will be checked randomly thereafter. If hot/cold food is found outside of acceptable temperature parameters, additional staff training and auditing will be done. Compliance will be reviewed during the June 2025 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion Date: May 16, 2025	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		5/16/25

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F 812	Continued From page 11 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators and dry storage were labeled, dated and discarded properly. This deficient practice had the potential to affect all 40 residents, staff and visitors who received food from facility kitchen. Findings include: During the initial kitchen tour on 3/31/25 at 11:35 a.m., dietary manager (DM) stated the dates listed on the food was the date of opening or when it was prepped and should be tossed after one week. The following items were observed in the fridge or dry storage with expired or undated food: -Hot dogs dated 3/16/25 -Bratwurst dated 3/17/25 -Tuna Salad dated 3/15/25 -Clam chowder dated 2/25/25	F 812	Regulation 483.60(i)(1)(2) Tag F812 Sanitary Food Storage, Preparing and Serving This plan of correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center stores, prepares, distributes, and serves food in accordance with professional standards for food service safety with the goal of providing the residents with a dignified dining experience with tasty, wholesome food in a homelike environment. The facility 1) obtains food for resident consumption	

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F 812	Continued From page 12 -Cranberry preparation date 3/19/25 -Celery preparation date 3/1925 -Corn preparation undated -Ground all spice, manufacturer expiration date 7/19/24 -Ground Cloves, manufacturer expiration date 9/5/24 During interview on 4/2/25 at 9:11 a.m., cook (C)-A and dietary aide (DA)-A stated the date on foods in the fridge are the dates they were open or prepped on. C-A and DA-A both stated the foods should be thrown one week after the date on the food. C-A and DA-A both stated everyone is responsible for throwing out expired foods. During interview on 4/2/25 2:45 p.m., dietary district manager (DDM) confirmed the facility policy is to date the food with the date it was opened or prepared; items should be thrown 7 days later. DDM verified the opened date on the hot dogs was 3/16/25 and should have been thrown by 3/23/25. DDM verified the opened date on the celery was 3/19/25 and should have been thrown by 3/26/25. DDM verified the manufacturers expiration date on the ground all spice was 7/19/24 and should have been thrown. Verified the manufacturers expiration date on the ground cloves was 9/5/24 and should have been thrown. Per facility Food Storage policy dated 2/23, storage areas will be neat, arranged for easy identification, and date marked as appropriate.	F 812	from vendors approved or considered satisfactory by Federal, State or local authorities 2) follows proper sanitation and food handling practices to prevent the outbreak of food borne illness and 3) ensures food safety is maintained during food storage, preparation, and serving. The facility contracts with Healthcare Services Group for all dietary related services. The policies and procedures for labeling and dating opened/prepared food and discarding outdated/expired food will be revised to provide more specific guidance to staff. The dietary staff will be reeducated on the procedures for identifying and discarding outdated foods. All food storage areas have been checked for outdated and expired food. To monitor compliance, the facility's dietary policies/procedures will be revised to require that the Dietary Manager/designee check all food storage areas for outdated food weekly on an ongoing basis. For two months a log sheet will be implemented to verify that any outdated/expired food has been identified and discarded. Monthly, the representative from the Healthcare Services Group conducts a random audit of the food storage areas to ensure proper storage including labeling and dating of opened/prepared food and discarding of outdated/expired food. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the June 2025 quarterly	

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F 812	Continued From page 13	F 812	Quality Assurance and Performance Improvement Committee meeting. Completion Date: May 16, 2025	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		5/16/25

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F 880	Continued From page 14 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper personal protective equipment (PPE) was utilized for 5 of 5 residents (R23, R6, R15, R21, R36) reviewed for enhanced barrier precautions (EBP).	F 880	Regulation 483.80(a)(1)(2)(4)(e)(f) Tag F880 Infection Prevention and Control This plan of correction constitutes a	

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F 880	Continued From page 15 Findings include: R23's face sheet printed 4/2/25, included diagnoses of chronic pain, artificial hip joint, weakness, and fistula of intestine. R23's quarterly Minimum Data Set (MDS) assessment dated 12/24/24, indicated moderately impaired cognition, no rejection of care, upper and lower extremity impairment, use of a wheelchair, substantial/maximal assistance with toileting hygiene, upper and lower body dressing. R23's care plan revised 1/5/24, indicated extensive assist with bathing, grooming, and dressing. R23's care plan further indicated incontinence of bowel and presence of nephrostomy (opening between kidney and the skin) for urination. R6's face sheet, included diagnoses of history of traumatic brain injury, benign prostatic hypertrophy (enlargement of prostate gland causing difficult urination), weakness, and pain. R6's significant change MDS dated 1/21/25, indicated moderately impaired cognition, no behaviors or rejection of care, use of a wheelchair, substantial/maximal assistance with toileting hygiene, bathing, dressing, and personal hygiene. R6's care plan revised 1/31/25, indicated urinary catheter for benign prostatic hypertrophy, urinary retention, and frequent urinary tract infections. R6's care plan further indicated R6 had all personal bowel and bladder cares provided by nursing staff.	F 880	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment for the residents and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. The IPCP is reviewed annually and updated as necessary. Antibiotic stewardship and infection control policy changes are reviewed with the Medical Director. The infection control policies address a system of surveillance to identify communicable diseases/infections before they can spread to other persons in the facility; when and to whom communicable diseases/infections should be reported; standard and transmission-based precautions to be followed to prevent the spread of infections; when and how	

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F 880	Continued From page 16 R15's face sheet printed 4/2/25, indicated diagnoses of congestive heart failure, obesity, chronic pain, open wound of scalp, and open wound of left lower leg. R15's quarterly MDS dated 1/22/25, indicated intact cognition, no rejection of care, impairment of left lower extremity, dependent on staff for toileting hygiene, and substantial/maximal assistance for bathing and dressing. R15's physician's orders printed 4/2/25, indicated wound to left lower leg with orders to cleanse with wound cleanser, apply dressing, cover with absorbent pad, wrap from foot to knee. Physician's orders further instructed to soak wound with acetic acid for 15 minutes daily. In addition, physician's orders directed to soak scalp wound gently with soap and water, pat wound dry, and bandage. Before applying bandage, wipe away any crusting that formed. R21's face sheet printed 4/2/25, indicated diagnoses of congestive heart failure, paraplegia (loss of muscle use in the lower half of the body), obesity, presence of urinary catheter, and open wound of the left thigh. R21's annual MDS dated 2/6/25, indicated intact cognition, no rejection of care, upper and lower extremity impairment, use of a wheelchair, dependent on staff for toileting hygiene, and substantial/maximal assistance with dressing, bathing, and personal hygiene. R21's care plan date 2/27/25, indicated presence of chronic pressure injury stage II due to lack of repositioning while out of the facility. R21's care	F 880	isolation should be used for a resident; circumstances when an employee with a communicable condition/infection would be prevented from direct contact with residents or food; and hand hygiene after each direct resident contact for which hand cleansing is indicated by accepted professional practice. In accordance with the Center for Disease Control March 2024 guidance and recommendations, the facility has developed policies and procedures addressing enhanced barrier precaution use. For residents with infection/colonization with a CDC-targeted MDRO, chronic wounds, and/or an indwelling medical device, gown and gloves are to be used when performing high-contact resident cares such as dressing, providing hygiene, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, providing wound care to any skin opening requiring a dressing, and device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator). The facility leadership team will use discretion when implementing and communicating the need for EBP and balance infection control interventions with the need to maintain a homelike environment for residents. The nursing staff will be reinstructed 1) that multidrug-resistant organism (MDRO) transmission is common in long term care facilities 2) that many residents in nursing homes are at increased risk of becoming	

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F 880	Continued From page 17 plan further indicated urinary incontinence and the presence of a suprapubic catheter (tube inserted into the bladder through incision in lower abdomen) and need for staff assistance with toileting and incontinence care. During interview and observation on 4/1/25 at 8:42 a.m., nursing assistant (NA)-C and NA-B assisted R23 with toilet use, transfer, and hygiene. R23 had an Enhanced Barrier Precautions (EBP) sign her room entrance door. NA-C and NA-B were not wearing gowns when providing cares to R23. NA-C stated she did not wear a gown to assist R23. NA-C further stated she was educated on EBP and should have worn a gown when providing cares to R23. NA-B state she did not wear a gown to assist R23, she knew the sign for EBP was on R23's door, but staff did not usually wear gowns because everything changes all the time, and she was not sure what she was supposed to do. During interview and observation on 4/1/25 at 12:57 p.m., NA-B assisted R6 with hygiene and emptying of urinary catheter bag. R6 had a sign on his room entrance door indicating the need for EBP. NA-B did not wear a gown to assist R6. NA-B stated she knew there was an EBP sign on R6's door, knew she should wear a gown to assist R6, but did not wear a gown. During interview and observation on 4/1/25 at 1:21 p.m., NA-B and NA-C assisted R15 with personal hygiene and brief change. R15 had an EBP sign on her room entrance door. NA-B and NA-C did not wear gowns while assisting R15. NA-B and NA-C stated they knew they should have worn gowns to assist R15 due to her wounds, but did not wear gowns.	F 880	colonized and developing infections 3) that MDROs contribute to serious health complications and increase the resident's healthcare costs and 4) of the CDC guidelines and recommendations for enhanced barrier precautions, including proper gown use. Infection control techniques are addressed during the new employee orientation and are included in the annual mandatory staff training. The records of residents number 6, 15, 21, 23, and 36 were reviewed by a registered nurse. The continued use of enhanced barrier precautions remains appropriate. The residents' infection control plans of care have been reviewed and revised as necessary. To monitor compliance, the Assistant Director of Nursing/designee will observe care givers for proper gown use when caring for residents requiring enhanced barrier precautions. Observations will be completed three times weekly for four weeks. These observations will be conducted on each resident care unit and during various shifts. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the June 2025 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion Date: May 16, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	04/03/2025

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F 880	Continued From page 18 During interview and observation on 4/2/25 at 8:46 a.m., NA-D assisted R21 with emptying his urinary catheter. R21 had an EBP sign on his room entrance door. NA-D did not wear a gown while assisting R21. NA-D stated she was unaware she was supposed to wear a gown while assisting R21 and did not know what the EBP sign meant. NA-D stated she would go find some gowns to use. During interview and observation on 4/2/25 at 8:49 a.m., NA-E assisted R15 with personal hygiene and brief change. R15 had an EBP sign on her room entrance door. NA-E did not wear a gown while assisting R15. NA-E stated she did not know she needed to wear a gown, was unsure which resident in the room required use of EBP and would have to go ask someone for answers. During interview on 4/2/25 at 9:04 a.m., licensed practical nurse (LPN)-A stated she would expect the nursing assistants to wear gowns when providing cares in EBP rooms. LPN-A further stated she was unsure why they were not wearing proper PPE for EBP because they had all had training on EBP. During interview on 4/3/25 at 9:43 a.m., director of nursing (DON) stated staff had been educated on EBP and she expected staff to use EBP when required. During interview on 4/2/25 at 10:11 a.m., infection preventionist (IP) and administrator stated they were not aware proper PPE was not being used for EBP resident rooms and would expect staff to wear gowns in EBP rooms to prevent spread of	F 880		

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F 880	Continued From page 19 infection. R36 significant change Minimum Data Set (MDS) assessment dated 3/17/25 indicated, R36 was moderately impaired with no behaviors, dependent on staff for all activities of daily living (ADLs), incontinent of bowel and bladder, received nutrition and fluid intake through feeding tube (tube surgically inserted in the stomach to provide artificial nutrition and fluids. R36's diagnoses list included encephalopathy [a disorder involving altered brain function related to underlying disease/condition], transient ischemic attack (TIA) [temporary loss of blood flow to the brain], cerebral infarction [death of brain tissue due to loss of blood flow], gastrostomy [feeding tube surgically inserted into the stomach], moderate protein-calorie malnutrition, and nontraumatic intracranial hemorrhage [bleeding in the brain not caused by external force]. R36's provider orders included NPO [nothing by mouth] total tube nutrition, Nutren 1.5 cal (brand of liquid nutrition) 500 ml three times a day, and water flushes 120 ml before and after each feeding. Provider orders also indicated route of administration for medications as "gastric tube". A careplan dated 3/14/25 indicated R36 2 staff to assist [R36] to reposition in bed and chair every 2 hours, 2 staff to assist [R36] to transfer to and from chair and bed using Hoyer lift (machine used to lift a resident completely from one surface to another), and extensive assist with dressing, bathing, and personal cares. It also indicated R36 was NPO total tube feed due to inability to swallow. The careplan lacked	F 880		

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F 880	Continued From page 20 indication of EBP. During interview on 3/31/25 at 5:54 p.m., R36's family member (FM)-A stated R36 requires tube feeding due to recent stroke and hospitalization for COVID. FM-A has not noticed staff wearing gowns when providing cares. During observation on 4/1/25 at 9:25 a.m., R36 was laying in bed with the head of his bed elevated. Bag dated 4/1/25 containing tube feeding solution was hanging from pole in the room. Enhanced barrier precautions sign was taped to the door. No PPE noted in or around R36's room. During observation and interview on 4/1/25 at 10:40 a.m., nursing assistant (NA)-A entered R36's room, applied gloves, and boosted R36 in bed by standing at the HOB and using soaker pad to boost resident in bed. NA-A then provided oral cares to resident using moistened sponges. During interview, NA-A stated staff are only required to wear gloves with EBP. NA-A stated carts with PPE are in the shower room in the middle of each hall. NA-A reiterated staff are required to wear gloves only for residents with EBP. NA-A and surveyor walked to shower room and observed a cart with drawers containing yellow gowns, gloves and other PPE. During observation and interview on 4/1/25 at 12:58 p.m., LPN-A arrived at R36's room and applied gloves. Without wearing a gown, LPN-A checked R36's residual volume [the volume of liquid remaining in the stomach]. LPN-A then administered water in R36's tube to flush tube and add fluid volume. After flushing the tube with water, LPN-A then hooked the liquid nutrition up	F 880		

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F 880	Continued From page 21 to the feeding tube. LPN-A then removed the gloves. When asked about the EBP sign of R36's door, LPN-A stated she forgot to put a gown on. LPN-A stated resident's who have wounds, catheters, and feeding tubes are required to be placed on EBP. LPN-A stated nursing assistants are also required to wear a gown. When asked where the gowns are located, LPN-A looked up and down the hall stating gowns are normally located outside the resident's rooms however, "In this one [hall] I think they are located in the shower room." LPN-A stated staff receive infection training yearly. The facility EBP sign posted on R23, R6, R15, R21, and R36's room entrance doors indicated the following: Enhanced Barrier Precautions- Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care. A facility policy titled Infection Control printed 4/3/25, indicated it was the policy of the facility that each resident and staff member be provided with a safe, sanitary and comfortable environment in which to live and work in by adapting processes to prevent development and transmission of disease and infection. An EBP policy was requested but not received.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		5/16/25

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F 908	Continued From page 22 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain kitchen equipment in safe operating condition. This had potential to affect all 40 residents, staff and visitors who consumed meals from the main production kitchen. Findings include: During interview on 4/2/25 9:11 a.m., cook (C)-A stated the left side of the plate warmer does not work, only plates on the right side get warm. C-A stated the left side had not functioned for some time. C-A stated she told the dietary manager (DM) a while ago, but the left side of plate warmer is still broken. C-A stated the broken plate warmer was a concern because the warmed plates help the food stay warmer longer. Food that is placed on the cold plates from the left side of the plate warmer cools faster and residents become unhappy when they eat cold food. During interview on 4/2/25 1:47 p.m., administrator stated the facility does not have or keep maintenance logs for the kitchen plate warmer. Administrator stated if dietary had a problem with the plate warmer, they should call maintenance and if maintenance can't fix it then they would have to call the manufacturing company. She stated she didn't think any of the equipment in the kitchen needed maintenance. During interview on 4/2/25 at 2:01 p.m., dietary	F 908	Regulation 483.90(d)(2) Tag F908 Maintain Patient Care Equipment in Safe Operating Condition This plan of correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Stewartville Care Center has policies and procedures in place to ensure that all mechanical, electrical and patient care equipment is in safe operating condition. The facility has created a policy titled, “Work Orders, Maintenance”, that provides guidance to staff in the timely and appropriate reporting of equipment that needs servicing/repair. The facility uses Worxhub software to manage routine equipment servicing/maintenance and staff requests for equipment service/repair. Staff have the ability to report equipment concerns using the Worxhub portal; the dietary staff have been instructed how to log repair requests into the portal. Work orders/requests submitted to the portal are monitored	

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F 908	Continued From page 23 district manager (DDM) stated the facility does not use a maintenance tracking system; they communicate by word of mouth. He stated he was unsure when the facility was aware the plate warmer was not working. Verified the plate warmer did not have a maintenance log associated with it. During interview on 4/2/25 at 2:13 p.m., DDM stated the dietary manager, and the maintenance team discussed the broken plate warmer approximately one month prior. DDM confirmed the plate warmer was not working earlier today. A facility equipment maintenance policy was asked for, none was provided.	F 908	daily; the Maintenance Director is responsible for ensuring task completion. Equipment malfunctions that may pose an immediate risk to residents, staff, visitors or the overall safety of the facility may be communicated verbally directly to the Maintenance Department staff and entered to WorxHub after completion for tracking purposes only. After it was reported that one heating element appeared to be malfunctioning on April 2, 2025, the plate warmer was removed from service and inspected. The plate warmer was found to have the heating elements turned to the low settings. The controls were adjusted to a higher temperature setting; the warmer was cleaned and returned to the kitchen. Both sides of the warmer are now functioning as designed. To monitor compliance, the breakfast cook will check the function of the plate warmer daily for one week, then weekly for one month and randomly thereafter. The Dietary Manager and other staff will also randomly check the function of the plate warmer. Any malfunction of the plate warmer or other equipment will be communicated to the Maintenance Director using the Worxhub portal. Compliance will be reviewed during the June 2025 quarterly Quality Assurance and Performance Improvement Committee meeting. Completion Date: May 16, 2025	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/01/2025. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. 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	K 000		

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K 000	Continued From page 2 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. The facility has a capacity of 58 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		4/2/25

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K 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/01/2025 between 9:00 AM and 2:30 PM, it was revealed by observation in the Electrical Room that cabling was attached to the sprinkler system. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 353	Tag K353 NFPA 101 Sprinkler System – Maintenance and Testing Stewartville Care Center has policies and procedures in place to ensure that the Automatic Sprinkler and Standpipe Systems are inspected, tested and maintained in accordance with NFPA 25. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked: January 17, 2025 b) Who completed the system test: Facility Maintenance Staff c) Water system supply source: City of Stewartville Maintenance staff removed the cabling that was attached to the sprinkler system in the Garden Level Electrical Room #11. This was completed on 04/02/2025. All staff will be educated on the regulation related to sprinklers and standpipes with the understanding to report if they observe anything attached to or potentially restricting the functionality of the Automatic Sprinkler System. The Facility Maintenance Director, Environmental Services Director or designee will monitor the sprinkler system to ensure that there is no cabling or other device attached to the sprinkler system or standpipe during routine inspections, testing and maintenance. Completion Date: April 2, 2025	

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K 712 SS=C	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 REQUIREMENT 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. Findings include: On 04/01/2025 between 9:00 AM and 2:30 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 Maintenance Director verified this deficient finding at the time of discovery.	K 712	Tag K712 NFPA 101 Fire Drills Stewartville Care Center has policies and procedures in place for completion of both expected and unexpected fire drills with varying conditions that are conducted at least quarterly on each shift. The Facility Maintenance Director and Environmental Services Director have reviewed the schedule that is in place for conducting fire drills to ensure that drills are conducted with more than ninety (90) minutes and less than two hours between drills quarterly. The facility has a planned drill scheduled for May 5, 2025. The Facility Maintenance Director, Environmental Services Director or designee will monitor the completed drill reports for appropriate randomness and	5/5/25

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(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
K 712	Continued From page 5	K 712	ensure these reports are maintained for review per the regulation. Completion Date: May 5, 2025	
K 918 SS=F	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 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	K 918		4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2025**

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K 918	Continued From page 6 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on 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, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/01/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that annual load-bank testing is occurring. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 918	Tag K918 NFPA 101 Electrical Systems – Essential Electric System Stewartville Care Center has policies and procedures in place for routine maintenance and testing of the facility generator. These tests are conducted by facility Maintenance Staff and a contracted vendor based on required schedules and test results. Findings during the survey of kW (Load Under Test) not hitting 33% Monthly Emergency Generator Testing expectations for the month of January, February, and March 2025 indicated a need for a 2-hour load test. The contracted vendor, Zieger Power System performed a Level 5 Service - Load Bank Testing -2 Hours. This was completed on 04/11/2025. The facility contract with Ziegler Power System was reviewed to ensure that this service is included in the agreement moving forward. Maintenance staff have been educated on the need to report any monthly generator test findings that show to be under the required load parameters. The Facility Maintenance Director or Environmental Services Director will	

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K 918	Continued From page 7	K 918	routinely monitor the generator testing logs to ensure the required follow-up testing is completed by the contracted vendor, Zieger Power System. Completion Date: April 11, 2025	