

Protecting, Maintaining and Improving the Health of Minnesotans

CERTIFIED MAIL 7010 1670 0000 8044 3755

January 26, 2016

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, MN 55976

Re: Stewartville Care Center Independent Informal Dispute Resolution Provider # 245349 Project # \$5349025

Dear Mr. Gustason:

In a request dated July 15, 2015, Stewartville Care Center requested removal of deficiencies cited at F223, F225, F226, F490 and F493 as a result of a certification survey completed on June 17, 2015 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated December 18, 2015. The revised CMS 2567 is enclosed.

Also, corresponding State licensing orders cited at have been reviewed and revised. The revised Minnesota Department of Health order form is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Hally Kranz

CC: Office of Ombudsman for Long-Term Care Mary Absolon, Program Manager Maria King, Assistant Program Manager Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			APPROVED		
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C		. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
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F 000	INITIAL COMMEN	rs	F 0	00			
F 166	Minnesota Departm 10, 11, 12, 13, 15, 1 resulted in an Imma and F225 related to comprehensively as allegations of abuse administrator and s implement interven free from abuse wh potential for harm of notified of the IJ on The IJ was remove p.m., however non- scope and severity that is not immedia An extended survey Minnesota Departm 15, 16 & 17, 2015. The facility's plan of as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electror be used as verification.	y was conducted by the nent of Health on June 12, 13, f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will	F 1	66			7/16/15
SS=E	RESOLVE GRIEVA			-			
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						07/17/2015

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.

PRINTED: 01/26/2016

	-	AND HUMAN SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245349	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 166	A resident has the in facility to resolve gri have, including those of other residents. This REQUIREMEN by: Based on observative review, the facility fi grievances were rearesidents (R53, R4 grievances were rearesidents (R53, R4 grievance to the factor Findings include: During an interview p.m. R53 reported long. R53 stated, "Samither of the states of the states night. I've told all the I've asked if they canothing happens. The states of the stat	Arright to prompt efforts by the rievances the resident may se with respect to the behavior NT is not met as evidenced tion, interview and document ailed to ensure resident solved promptly for 4 of 4 6, R7 & R66) who expressed a cility staff. Arr with R53 on 6/8/15, at 6:05 her roommate hollers all night She sleeps all day, hollers all the nurses. Nothing gets done. an give her a private room, but They try different stuff, it keeps me up all night. They or me." R53's medical record dated . indicated R53 had reported, er hollering." Another note a.m. indicated, "message left es] telephone in regards to 5/3/15 at 5:13 a.m. a nurse's , "asked her [R53] what she [R30's] bed during the night	F 1	Stewartville Care Center staff the residents; right to autonom choice and protects and prome residents; legal rights as well a right to privacy and a dignified The staff encourage the reside concerns about care and/or se respect their right to have prom attention to help resolve grieva including concerns about the b other residents. The policies and procedures for responding to residents; grieva reviewed and found appropriate receiving a complaint/grievance facility seeks a resolution in a t manner and keeps the residen appropriately apprised of the pr toward resolution. The resident are asked about care concerns quarterly interdisciplinary care conferences.	ay and between the as their existence. Ints to voice rvices and apt staff nces ehavior of r ances were e. After e, the imely t rogress s/families o during the dure is	
	and she states she was giving her a stuffed animal to hold so she wouldn't holler" R53's quarterly Minimum Data Set (MDS) dated 3/18/15, identified intact cognition with no behavioral or communication issues.			explained to the resident at the admission and grievance forms provided in the admission pack Grievance forms are also avail nursing desks and first floor re- area. Concerns expressed oral	s are lets. able at the ception	

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPL			0938-039
	F CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
		245349	B. WING _			06 /1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 166	Continued From pa	age 2	F 16	56			
	During an interview a.m. R46 state, "at hollers. It keeps mo An entry in R46's m at 4:43 a.m. include during the night be her awake which u that makes her ner R46's annual Minin 4/29/15, indicated t cognition with no b issues. During an interview p.m. R7 stated, "we door that yells befo During an interview p.m. R7 said she h of nursing (DON) a night, so the DON room, "but she is n R7's annual MDS of had intact cognition communication iss During an interview p.m. R66 said, "It is yelling for help a lo R66's quarterly MD resident was cogni	 with R46 on 6/9/15, at 09:23 different times someone e up at night." nedical record dated 5/16/15, ed, "States she can't sleep cause her roommate keeps sually sets off the alarm and vous Message left for SS." num Data Set (MDS) dated the resident had intact ehavioral or communication with R7 on 6/8/15, at 6:36 e have a person (R30) next ore she goes to bed." with R7 on 6/11/15, at 3:40 ad complained to the director about the noise R30 made at had moved R30 to another ow in the room next to me." dated 3/31/15, identified R7 n with no behavioral or ues. with R66 on 6/8/15, at 06:44 s noisy because another lady is t at night." 			the comment form is reviewed by the social worker and addressed in a tir manner. Residents; grievances and concerns are routinely reviewed dur the shift-to-shift reports, quarterly ca conferences, and the Quality Asses and Assurance Committee meeting. During the mandatory meetings July 15 and 16, 2015, the staffs were rer of the residents; right to report grievances and care concerns and r responsibility to respond appropriate in a timely manner. Discussion will i the residents; right to have 1) custor routines respected and accommoda fullest extent possible and 2) a quie environment that promotes restful s The staff were reminded of the procedures to alert the social worke other appropriate staff of their concerns/observations and the cond expressed by the residents/families Residents; rights are reviewed with staff annually and are included as p new employee orientation. Satisfaction with cares and services continue to be discussed during ead resident; s care conference and mo often as necessary. Residents will b asked about their satisfaction with r levels during the night during the ne three resident council meetings.	mely d ring are sment s. y 14, minded their ely and include omary ated to t er and cerns t er and cerns s will ch ore obe noise ext	
	or communication				The record of resident number 30 w reviewed; there was no recent documentation of incidences of nigh		

Facility ID: 00429

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						MB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245349	B. WING _			06 /1	7/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAF	TVILLE CARE CENTI	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 166	on 6/11/15 at 2:32 p	o.m., NA-D said, "I have heard	F 16	66	yelling. The Assistant Director of Nu will meet with the nurses on the nig			
	[R30] yells a lot at night from the night staff." During an interview on 6/11/15, at 2:41 p.m. licensed practical nurse (LPN)-J said, "(R30) has a problem yelling and cries at night. The staff will try to medicate her and sit with her. This happens at least a couple times a week. Her roommate has said she (R30) has kept her up all night. Everybody is aware of it, social services				to discuss the past behavior of residents. The resident will be reast residents. The resident will be reast for symptoms of pain and her sleep will be monitored and documented nightly for 14 nights. If there are con incidences of yelling, the interdiscip team will meet to assess the reside	dent hear by sessed habits for ntinued olinary		
	(SS), the director of why we can't fix it." During an interview 9:55 a.m., LPN-K s but it has been a pr	with LPN-K on 6/12/15 at tated, "(R30) slept last night oblem with her yelling in the t at night or at least makes			behavior and discuss further interve to promote a restful environment; th resident¿s attending physician/nurs practitioner will be notified of behav symptoms adversely impacting othe residents.	entions ne se rior		
	know about it but it During an interview p.m., SS-A stated, ' grievances for the about (R30) crying grievance form abo grievance form on a residents to use the to get to her (R30) a hollers and cries ou	hes a week. SS and the DON is a difficult issue to resolve." with SS-A on 6/11/15 at 2:56 'I don't have any written past six months. I have heard out but I have not gotten a ut it. Everyone is given a admission. We do not remind e grievance form. The staff try as fast as they can but she still it." on 6/11/15 at 5:24 p.m., the			Resident number 53 - The staff hav informed of the resident¿s concern regarding the sleep disturbing beha resident number 30. The staff will n the night time behavior patterns of resident number 30 and implement interventions to minimize the disturl of near by residents. The social wo will interview the resident at least w for three weeks to determine wheth there are ongoing concerns regardin night time noise levels. If concerns voiced, additional monitoring will be and alternative interventions	bance rker reekly her ang the are		
	DON said he was n people awake at nig aware of the daytim knew the grievance "repaired." An undated facility	ot aware [R30] was keeping ght but acknowledged, "I was ie noises." The DON stated he process needed to be policy entitled, Filing aints indicated: "Grievances			attempted/implemented. Resident number 46 - The staff hav informed of the resident¿s concern regarding the sleep disturbing beha resident number 30 and the safety used by her roommate. The staff w monitor the night time behavior path	avior of alarms ill		

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	E SURVEY PLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHI STEWARTVILLE, MN 5597		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 166	and/or complaints r writingthe admini responsibility of grie investigation to Soc grievance and/or co investigate the alleg report of such findi	age 4 may be submitted orally or in strator has delegated the evance and/or complaint cial Services. Upon receipt of a omplaint, Social Services will gation and submit a written ng to the administrator within f receiving the grievance	F 1	 66 resident number 30 and roommate;s safety ala worker will interview the weekly for three weeks whether there are ongo regarding the night time. Interventions to minimiz will be discussed/implet resident;s ongoing satistaff responses to conce addressed as necessar was visited by the socia 2015 and she expressed moving to a different ro; content and agreeable be offered the first wind become available. Resident number 7 - Thinformed of the resident regarding the sleep dist resident number 30. W during her care conferent the resident stated that resident number 30 we her sleep. The social we the resident at least we weeks to determine whongoing concerns regarding the sleep dist resident number 30. The niformed of the resident at least we weeks to determine whongoing concerns regarding the sleep dist resident number 30. The niformed of the resident at least we weeks to determine whongoing the sleep dist resident number 66 - Thinformed of the resident regarding the sleep dist resident number 30. The night time behavior 	rms. The social e resident at least to determine ing concerns e noise levels. the noise levels mented and the sfaction with the erns will be y. The resident il worker July 14, d interest in om. She is e; with the plan to ow beds that the staff have been t; s concern urbing behavior of hen questioned nce July 14, 2015, the behaviors of re not disturbing orker will interview ekly for three ether there are roling the night time is are voiced, ill be done and t; s concern urbing behavior of e staff have been t; s concern urbing the night time s are voiced, ill be done and t; s concern urbing behavior of e staff will monitor	

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		AND HUMAN SERVICES			FORM	D: 01/26/2016 APPROVED D: 0938-0391
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245349	B. WING			/17/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWA	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	483.13(b), 483.13(c ABUSE/INVOLUNT The resident has th sexual, physical, ar punishment, and in The facility must no	c)(1)(i) FREE FROM TARY SECLUSION he right to be free from verbal, nd mental abuse, corporal voluntary seclusion. bt use verbal, mental, sexual, corporal punishment, or	F 1		resident number 30 and implement interventions to minimize the disturbance of near by residents. The resident resides across and down the hall from resident number 30 and has a very severe hearing deficit when not wearing her hearing aide which she removes at night. The social worker will interview the resident at least weekly for three weeks to determined whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitoring will be done and alternative interventions attempted/implemented. The night nurses will document the behaviors of resident number 30 nightly for 14 nights; the data will be assessed to determine whether additional intervention are necessary to address night time behaviors. The Social Worker will monitor resident satisfaction with a restful sleep environment during one-to-one visits, care conferences, and resident council meetings for the next 90 days and randomly thereafter.	g s s

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 223	by: Based on observat review, the facility fa (R75 and R65) revie from verbal and phy facility staff were av not immediately rep further abuse from to implement interva abuse resulted in at R75, R65 and other main and lower floo perpetrator worked. The IJ began on 4/2 observed the abuse preventative interver and ongoing educa therapeutic interver residents with cogn immediately report abuse from reoccur (DON) and adminis immediate jeopardy inmediate jeopardy	NT is not met as evidenced ion, interview and document ailed to ensure 2 of 2 residents ewed for abuse, were free ysical abuse by staff. Although vare of the abuse, the staff did port/intervene to prevent occurring. The facility's failure entions to prevent continued n immediate jeopardy (IJ) for r residents residing on the or levels where the alleged 24/15, when facility staff had a but failed to implement entions, failed to provide initial tion to staff for use of ntions when dealing with itive deficits, and failed to the abuse as efforts to prevent rring. The director of nursing trator were notified of the v at 3:00 p.m. on 6/12/15. The v was removed on 6/16/15, but hained at a lower scope and isolated scope and severity (bruising and swelling of R65's	F 2	223	Preparation, submission and implementation of this Plan of Correct does not constitute an admission of a greement with the facts and conclus set forth in the statement of deficient The facility has appealed the deficient and licensing violations stated herein Plan of Correction is prepared and/o executed as a means of continuously improve the quality of care, to compli- all applicable state and feral regulator requirements and constitutes the fac- allegation of compliance. Stewartville Care Center policy requi- that each resident be free from verba- sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident will not be subjected to abuse by anyone, include but not limited to, facility staff, other residents, consultants, volunteers, st other agencies serving the resident, members or legal guardians, or othe individuals. The facility¿s policies and procedure investigating/reporting of incidents w reviewed and found appropriate. The facility¿s Vulnerable Adult Abuse poli- were distributed to all staff on June 1 June 17, 2015. The staff were requir- sign to verify that they received the information. On June 16, 2015, all Stewartville Ca	or isions cies. ncies n. This y ly with ory cility¿s ires al, y ding, taff of family er es for vere e licies 16 and red to	

Facility ID: 00429

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEA STEWARTVILLE, MN 55976	ST	
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F 223	Continued From pa	age 7	F 22	23		
	interventions initiate A facility COMPLAI REGARDING an E completed by nursi 4/25/15. The conce [LPN-E's first name CONCERN: Upon I residents from supp heard a lot of comm that the nurse [LPN at resident [R75]. V her room, she [R75 question and he sta That's when we rem situation" R75's quarterly min 5/12/15 indicated F mental status (BIM R75 was severely of also indicated R4 c difficulty. During an interview 9:51 a.m., R75 was with family (F)-A. F the surveyor withou R75's care plan dim careful, explanation comprehensionref	ected staff to provide, "Clear,		 were instructed on the foll definition of a vulnerable a mandated reporter of actures ident abuse/neglect/m of property 3) the types of must be reported to the capoint and/or the Minnesot Health 4) the requirement reporting of alleged abuse misappropriation of funds supervisory/administrative appropriate governmenta 5) forms and procedures and timely reporting. The on vulnerable adult issues twelve months; vulnerable investigation and reporting during new employee oried. The employee (LPN-E) in April 24, 2015 incidents winumber 65 and 75 was in for three days pending an the alleged abuse. After rhe was assigned to anoth After the June 2015 state issue, the LPN-e was required treatment/counse employee returned to wor no further practice/perform 	adult 2) who is a ual or suspected isappropriation f incidents that ommon entry a Department of ts of immediate e/neglect and to the e staff and I agencies and for appropriate staff is educated s at least every e adult g are addressed entation. volved in the vith residents itially suspended investigation of eturning to work, her care unit. review of the uested to sional Services condition of he program ues which eling. The k and has had	
	investigation of the interview conducted	ed by the DON related to the se incidents, included a typed d 4/25/15 at 10:00 a.m., by the he interview documentation		Resident number 65 ¿ TI continues to wander throu floor of the facility. She ha	ughout the first	

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED	
		245349	B. WING			06 /1	7/2015	
IAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 223	Continued From pa	age 8 o [NA-L] concerning incident	F 2	23	altercations with staff; her usual			
	was talking to [R75 questions and as [I questions he was b yelling, and was pr should. [R65] was walker but did not s (NA-L) heard a little (certified nursing a at staff, kicking and her walker."	a. shift. She stated he [LPN-E] b]. [R75] was repeating LPN-E] was answering becoming more upset and obably yelling more than he standing nearby with her say anything. Stated she le later from another CNA ssistant) that [R65] was hitting d attempting to hit them with bunt of these incidents had by LPN-J on 4/25/15. LPN-J's			resistiveness to bathing continues. resident has severe cognitive impa- and believes that she works at the and is a care taker for her grandpa She does not recall the incident fro 2015. The social worker frequently interacts with the resident as she w the social service office several tim day. The social worker will meet w resident weekly for four weeks and monthly for six months to assess m and behavior. The care plan was m and found appropriate.	airments facility arents. om April valks by nes a ith the I then nood		
	account included, ' for staff potluck, ow member [LPN-E] a see who it was but [R75]. Went out for when a staff memb had stated 'could ju back in I asked [LF 'we had a call in fo grandson was back call to see if I could night shift, he said page from another (RN)-H], had me co and talk with [assis (ADON) RN-A]. Dis	YON Friday 4/24/15 I was here verheard loud voice of a staff ddressing a resident. I did not another staff stated it was r a smoke break after eating, ber came out and said [LPN-E] ust kill them all'. When I came PN-E] if he was ok, he stated r night shift', (he also said his k in the hospital.) I offered to d get someone to come in for that would be great. Received staff [registered nurse ome down to the breakroom stant director of nursing scussed issue regarding decided [LPN-E] would be			Resident number 75 ¿ The resider cognitive deficits and self-propels I wheelchair around the facility. She occasional negative interactions w residents which require staff interv She does not recall the incident fro 2015. The social worker will meet v resident weekly for four weeks and monthly for six months to assess r and behavior. The resident frequen visits the Social Worker¿s office w obtain a piece of candy from the ca bowl. The care plan was reviewed found appropriate. The Social Worker will monitor compliance by auditing incident rep timely and appropriate notification administrator and government offic	her has ith other ention. om April with the then nood htly ork to andy and borts for of the		
	statements, followi R75, LPN-E was ir However, LPN-E c	iews and written witness ng the verbal altercation with Istructed to go home. ontinued to remain in the inuous supervision or			the next three months. If noncomp is noted, additional auditing and sta training will be done. Compliance w reviewed during the September Qu Assessment and Assurance Comp	liance aff vill be Jality		

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		IDENTIFICATION NOWDER.	A. BUILDI	NG		
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 120 FOURTH STREET NORTHEAS		
STEWAR	TVILLE CARE CENT	ER		STEWARTVILLE, MN 55976		
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F 223	Continued From pa immediate removal	ge 9 from resident access.	F 2:	23 quarterly meeting and ong	oing.	
	LPN-E verbally and the altercation with R65 sustained an in facility's time clock punched out from h	Physically abused R65 after R76. During that altercation njury to her left hand. The records indicated LPN-E had his shift at 7:37 p.m., hour after the incident of			ung.	
	note in R75's media (7:38 p.m.) which ir 4/24/15. Several sta conference room w raising his [LPN-E] writer came out in a resident [R75] need to her room." The stated, "she can dri to go," and had the about arguing with documented, "Able	to redirect the resident and DON, ADON and social				
		ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the ccility.				
	had an active Minn had been employed 2015. Review of LI record indicated tha Abuse Protocol trai had not received tra cognitively impaired the incidents of alle	record was reviewed. LPN-E esota Nursing License and d at the facility since January PN-E's in-service training at LPN-E had received initial ning during orientation, but aining on dealing with d residents since hire until after ged abuse on 4/24/15. LPN-E ne education related to Abuse				

Facility ID: 00429

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	ΞR			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	Prohibition/Residem Alzheimer's client o During an interview p.m., NA-C recalled stated, "I was sitting heard [LPN-E] yellin NA-C then explaine hallway near the nur re-direct R75, "We but then she [R75] a question and he sta her again. We were from the situation." remember what LP screaming about. During an interview indicated she could that had taken place However, she state heard LPN-E yelling remember what had confrontation but st least 10 minutes. N been interviewed at aware she could rep agency. During an interview DON was asked to regarding the imme allegations of abuse residents to the adr and any intervention other residents, or a incident. The DON	t rights/Caring for the	F2	223			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From pa physical abuse alleg R65. During a follow-up i at 2:34 p.m., NA-C after dinner which v stated, "[LPN-E] wa him down the hallw yelling was all about was in her face yell the wheelchair, and confused than usua after the incident R man was yelling at me?" until she went besides the repeate anxious and quiet th went to bed. NA-C who she'd told about The facility COMPL REGARDING an El NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L] grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4/2	ge 11 gation between LPN-E and nterview with NA-C on 6/12/15 stated the yelling had started vas around 6:30 p.m. NA-C is really loud, we could hear ay. We went to see what the t, when we went up there, he ing at her, she was sitting in 1 think [R75] was more al." NA-C further explained that 75 had kept repeating, "That me, why was he yelling at to bed. NA-C stated that ed question, R75 had been he rest of the night until she stated she could not recall ut the incident. AINT/CONCERN FORM MPLOYEE completed by so included:"Around 7:40 ask nurse [LPN-J] a question it [R65] standing by the med PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to went over and intervened. I int [R65] down afterwards but	F 2				
	regarding [LPN-E] a would be asked to g	nd included: "Discussed issue and it was decided [LPN-E] go home. He was finishing up at cart when [R65] came up,					

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	-	AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	grabbed the water p with it. He grabbed back on cart. She th to hit him with it, no she dropped it but i picked it up and [Re closed fist at which asked [R65] to leav [LPN-E] left shortly Another witness sta physical abuse of F RN-H on 4/25/15 ar the interaction betw 4/24/15 as I was on [RN-A]. I was inform gotten in [LPN-E's] fact that [LPN-E] ha around [R65] until 1 [NA-C] is filling out was reported to my aware of this situati had occurred by [LF soon as able." R65's quarterly MD R65 had a BIMS so cognitive impairment R65's care plan ver demonstrated behavinter interventions includ receptive when she her using calm, direc Review of R65's me certified nurse prace	pitcher, and tried to hit him it out of her hands and set it hen raised up her walker, as if it sure if he knocked it down or it fell on the floor. [LPN-E] 65] went as if to hit him with a time I got between them and re the area which she did. after that." atement regarding the alleged 865 had been documented by nd included: "I did not witness veen [LPN-E] and [R65] on n phone [symbol for with] ned by [LPN-J] that [R65] had face but was unaware of the ad put his arm and hand 11 p.m. on 4/24/15. CNA an incident report stating it rself and [LPN-H]. I was made ion 4 hours [symbol for after] it PN-B]. I reported incident as CS dated 4/28/15, indicated core of 4 indicating severe nt. rified the resident avioral problems and led: "She is much more e has familiar staff working with ect approach."	F 223			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING	i		06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	documented as an physical assault." T included: "Charge r patient was physica on April 24, 2015. A the patient had bee another eyewitness the event. Patient had laryngeal edema, si Director of nursing notified. A vulnerab Olmsted County. N patient be evaluated assault. Patient has her neck. There is n evidence of finger p area. She has some her left hand and nu some mild soft tissa after the incident with An additional entry at 6:18 p.m. include informed me that pa- with a staff nurse of was agitated and at pitcher at the nurse grabbed the patient water pitcher with th some mild swelling thumb web space v incident. Today she noted on her left ha her left thumb after resolved. Director of were notified. A vul-	age 13 "Evaluation of patient after The documented assessment hurse has informed me that ally assaulted by a staff nurse According to the charge nurse, en placed in a chokehold per a No bruising was noted after had no difficulty breathing, no tridor, or tracheal deviation. and Social Services were ble adult form was filled with ursing is requesting that d for any potential injury from s no evidence of any trauma to no bruising, abrasions, orints on her neck or shoulder e resolving bruising noted on urse reported that she has ue swelling of her left thumb hich has now resolved" written by CNP-D on 4/28/15 ed, " Charge nurse has atient [R65] had an altercation n April 24, 2015. The patient ttempted to throw her water e. The nurse reached and t's wrist with one hand and the he other hand. There was noted on the patient's left with a bruise occurring after the e has some resolving bruising and and no further swelling of the incident which has now of Nursing and Social Services nerable adult form was filled ty. Nursing is requesting that d for any potential injury from e [R65] denies all complaints of	F2	223			

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245349	B. WING		06/ [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
STEWAF		ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	pain today. Patient trauma to her body or change in her fur During an interview regards to when he incident with R65 w evening meal, DON phone message on incident but he did morning (Saturday come to the facility The DON stated it w director of nursing, administrator, or so internal investigativ designated agency. The facility provided submission report t Health Facility Com investigative notes According to the re allegations were no allegation of physic been reported the of 4/25/15. There had allegation of verbal documentation indi- had been submitted report included LPN abuse of R65 howe witness accounts o and accounts from the CNP's assessmi indicated R65 had s	has no evidence of any with no bruising or abrasions, nctional status" on 6/11/15, at 9:34 a.m. in was notified of the abuse which occurred on 4/24/15 after stated staff had placed a his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, ocial worker to submit any re reports to the State	F 223			

		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	assessment complete had been swelling a The investigative re- personal improvem included education dementia training, f report to the board to another unit. During an interview 9:45 a.m., the DON counseling, educati behaviors especiall might become agita the DON stated the followed-up with LP incidents for R75 at employed by the fa- documentation as t was working on in r improvement, comp dementia related be personal stress in a abuse situations fro RN-A was interview she verified that LP Protocol training du received training or impaired residents incidents of alleged RN-A verified that fu- had been required to related to Abuse Pr rights/Caring for the Following the surver	eted on 4/28/15 verified there and bruising of R65's left wrist. eport also documented a lent plan for LPN-E that re., vulnerable adult and follow up with social worker, of nursing, and reassignment with the DON on 6/12/15 at I stated LPN-E receiving ion on dealing with difficult ly residents with dementia who ated and combative. However, e social worker who had PN-E after the alleged abuse nd R65 was no longer cility and there was no to what improvements LPN-E regards to his performance petence of handling agitated ehaviors, or dealing with a healthy manner to prevent om redeveloping. Wed on 6/12/15, at 11:57 a.m. PN-E had received initial Abuse uring orientation, but had not n dealing with cognitively since hire until after the I abuse on 4/24/15. ollowing the incidents, LPN-E to complete online education rohibition/Resident e Alzheimer's client on 4/28/15.	F2	223			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING _			06 /-	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	abuse R75 had sus was made on 6/12/ plan of correction for been informed that situation existed. The the State agency in [Minnesota Departh to this writer's atten [LPN-E] was yelling was initially reporter another demented the main focus of the information in regar investigation of R65 was also agitated a responding to re-din at resident due to h [R75] and her conti- initially combined be nurse [LPN-E] into- now reporting this p separate incident On 6/16/15 all staff facility's abuse prote- from the assistant of reported for work. read the packet of i abuse protocol. The policies entitled: Ba Investigations, In-S Resident Abuse, Re Symptoms of Abuse Reporting/Investigation, Prote- Abuse Investigation, Prote-	DHFC) regarding the verbal stained on 4/24/15. The report 15, as part of the immediate ollowing the facility having an immediate jeopardy he incident description sent to cluded: "During routine MDH ment of Health], it was brought tion that on 4/24/15, staff LPN at resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was nat OHFC report and rds to R75 was to support the 5. During this incident [R75] and following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a ." received a copy of the ocol packet (forms undated) director of nursing as they The staff were requested to information in regards to a packet included specific tokground Screening ervice Training, Preventing ecognizing Signs and e/Neglect,	F 2	23			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING	à		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	·		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENT	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	Rape, Vulnerable A Misappropriation of Investigating Unexp Resident-to-Reside In addition the pack undated facility poli Life-Dignity, Employ Keys to Resident Li and Indicators of N Interviews were con direct care staff, ac and supervisory nu shifts on 6/16/15 be p.m. to verify receip their shifts. Each st they had received a were in the process facility's IJ removal RN-A was interview RN-A stated all staff described as they r Facility policies relar reviewed. An undat Reporting/Investiga Accidents/incidents reported to the dire immediately to the accidents/incidents thoroughly investiga findings of such inv by the Director of N An undated policy of Investigation includ	ed Cases and/or Incidents of adult Reporting of Alleged f Residents Personal Property, plained Injuries, ent Abuse, and reporting forms. Ket of information included icies for Visitation, Quality of yee In-Service Program, Six oyalty, Indicators of Abuse, eglect. Inducted by survey staff with stivities staff, pool nursing staff, rrsing from day and evening etween 2:20 p.m. and 2:40 of of education prior to starting taff person interviewed verified a packet of information and s of reading it as detailed in the plan. Wed on 6/16/17 at 2:45 p.m ff were provided training as reported to work. ated to Abuse Prohibition were ted policy entitled ating Resident s included: "All involving residents must be foctor of nursing services and administratorAll involving residents will be ated by management and the vestigation will be kept on file	F	223	3		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245349	B. WING			06 / ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From pa investigated."	ge 18	F 2	223			
F 225 SS=K	State Agencies and included, "All allege substantiated incide immediately to the A reported to appropr The immediate jeop was removed on 6/ determined the faci plan for removal in as they reported to policies related to a and reporting prior to residents. In addition been developed and complaince with face non-compliance rem 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en	(c)(2) - (4) PORT DIVIDUALS t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry	F2	225			6/17/15

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING _		06/ ⁻	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
0751445				120 FOURTH STREET NORTHEAST		
SIEWAH	TVILLE CARE CENTI	ER		STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thorou prevent further pote investigation is in pu The results of all im to the administrator representative and with State law (inclu certification agency incident, and if the a	unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 22	25		
	by: Based on observat review, the facility fa allegations of verba administrator and S thoroughly investiga neglect, and/or misi (R75, R65) reviewe ensure residents we abuse. The facility's abuse/neglect/malte following identificati resulted in an imme for R75 and R65 as who resided on the	NT is not met as evidenced ion, interview and document ailed to immediately report al and physical abuse to the state agency, failed to ate allegations of staff abuse, treatment for 2 of 5 residents d for abuse, and failed to ere protected from further s failure to operationalize their reatment policy/procedures on of abuse to R75 and R65, ediate jeopardy (IJ) situation s well as for other residents main and lower floor living ged perpetrator worked,		Preparation, submission and implementation of this Plan of Corr does not constitute an admission of agreement with the facts and conc set forth in the statement of deficie The facility has appealed the defici and licensing violations stated here Plan of Correction is prepared and executed as a means of continuou improve the quality of care, to com all applicable state and feral regula requirements and constitutes the fa allegation of compliance.	of or lusions ncies. encies bin. This /or sly ply with ttory acility¿s	

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							0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	PLETED
		245349	B. WING			06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225	Continued From pa	lge 20	F 2	25			
	neglect, and/or mis In addition the facili abuse/neglect polic reporting, investiga residents if allegatia and mistreatment for reviewed (R64, R99 The immediate jeop facility staff witness (LPN)-E verbally at abuse R65. The di administrator were jeopardy at 3:00 p.1 The immediate jeop but noncompliance and severity level of severity of no actual than minimal harm jeopardy. Findings include: Although R75 was at by licensed pract	ity failed to operationalize their by that clearly identified tion, and protection of on/s of staff abuse, neglect, or 3 of 6 other allegations 9, and R98). Deardy began on 4/24/15 when ted licensed practical nurse puse R75 and then physically rector of nursing (DON) and notified of the immediate			that all alleged violations involving resident mistreatment, neglect, abu- injuries of unknown source and misappropriation of property be 1) reported immediately to the adminis and appropriate state agencies and thoroughly investigated in a timely n with the investigative results reported the administrative staff and state off as required. If the alleged violation i verified, appropriate corrective action be taken. The facility intervenes to p further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who h been found guilty of abusing, negled or mistreating residents. Any knowled of actions against an employee whice would indicate unfitness for service resident care position is investigated reported to the State nurse aid regis licensing authorities. The facility is policies and procedures for investigation/reporting of incidents w reviewed and found appropriate. Th facility is Vulnerable Adult Abuse policies and procedures for	ave cting, ed and stry or were le	
	subsequently obse physically abusive to however, the incide reported to the adm nor were intervention abuse. A facility COMPLAI REGARDING an E	rved to be verbally and to R65 that same evening, ents were not immediately ninistrator or the State agency, ons initiated to prevent further NT/CONCERN FORM MPLOYEE had been ng assistant (NA)-C dated			were distributed to all staff on June June 17, 2015. The staff were requi sign to verify that they received the information. On June 16, 2015, all Stewartville C Center staff including management were instructed on the following: 1) definition of a vulnerable adult 2) wh mandated reporter of actual or susp	16 and red to care staff the no is a	

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	-	AND HUMAN SERVICES				FORM /	01/26/201 APPROVE <u>0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (/	. ,	SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 225	NAME: [LPN-E's fir CONCERN: Upon r residents from supp heard a lot of comm that the nurse [LPN at resident [R75]. W her room, she [R75 question and he sta That's when we rem situation" R75's quarterly min 5/12/15 indicated R mental status (BIM R75 was severely of also indicated R4 c difficulty. During an interview 9:51 a.m., R75 was with family (F)-A. F the surveyor withou surveyor did not ha to hear. R75's care plan direct careful, explanation comprehensionref needed to facilitate Information provide investigation of these interview conducted DON with NA-L. Th included, "Spoke to Friday 4-24-15 p.m was talking to [R75 questions and as [L]	st name] "COMPLAINT OR returning from bringing ber co-worker [NA-E] and I notion/screaming. We noticed I-E] was yelling and screaming Ve tried to take her [R75] to i] asked [LPN-E] another arted yelling at her again. noved her [R75] from the imum data set (MDS) dated t75 had a brief interview for S) score of 4 which indicated cognitively impaired. The MDS ould hear with minimal r and observations on 6/9/15 at s observed during an interview 875 conversed with F-A and at hearing difficulty and ve to speak loudly for resident	F 2	25	of property 3) the types of incidents to must be reported to the common ent point and/or the Minnesota Department Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies at 5) forms and procedures for appropriate and timely reporting. The staff is edu on vulnerable adult issues at least event twelve months; vulnerable adult investigation and reporting are addred during new employee orientation. The employee (LPN-E) involved in the April 24, 2015 incidents with resident number 65 and 75 was initially suspect for three days pending an investigati the alleged abuse. After returning to he was assigned to another care uni After the June 2015 state review of t issue, the LPN-e was requested to complete a Health Professional Serv Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has no further practice/performance issue Resident number 75 ¿ The resident cognitive deficits and self-propels he wheelchair around the facility. She h occasional negative interactions with residents which require staff interver She does not recall the incident from 2015. The social worker will meet wir resident weekly for four weeks and the resident weekly for four weeks and the	try ent of diate nd and riate ucated very essed he ts ended ion of work, it. the vices f n had ues. has er nas n other ntion. n April ith the	

Facility ID: 00429

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		AND HUMAN SERVICES			0		APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/-	17/2015
NAME OF	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 225	should. [R65] was s walker but did not s (NA-L) heard a little (certified nursing as at staff, kicking and her walker." Another typed acco been documented l account included, " for staff potluck, ov member [LPN-E] as see who it was but [R75]. Went out for when a staff memb had stated 'could ju back in I asked [LP 'we had a call in for grandson was back call to see if I could night shift, he said page from another (RN)-H], had me co and talk with [assis (ADON) RN-A]. Dis [LPN-E] and it was asked to go home.' According to intervi statements, followin R75, LPN-E was in However, LPN-E co facility without conti immediate removal LPN-E verbally and the altercation with	bably yelling more than he standing nearby with her say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with but of these incidents had by LPN-J on 4/25/15. LPN-J's On Friday 4/24/15 I was here erheard loud voice of a staff ddressing a resident. I did not another staff stated it was a smoke break after eating, ber came out and said [LPN-E] ust kill them all'. When I came eN-E] if he was ok, he stated r night shift', (he also said his k in the hospital.) I offered to I get someone to come in for that would be great. Received staff [registered nurse ome down to the breakroom tant director of nursing scussed issue regarding decided [LPN-E] would be	F 2	225	monthly for six months to assess m and behavior. The resident frequer visits the Social Worker¿s office to a piece of candy from the candy be care plan was reviewed and found appropriate. Resident number 65 ¿ The reside continues to wander throughout the floor of the facility. She has had no altercations with staff; her usual resistiveness to bathing continues. resident has severe cognitive impa and believes that she works at the and is a care taker for her grandpa She does not recall the incident fro 2015. The social worker frequently interacts with the resident as she w the social service office several tim day. The social worker will meet wi resident weekly for four weeks and monthly for six months to assess m and behavior. The care plan was m and found appropriate. Residents number 64 ¿ The allege abuse by the resident¿s spouse w observed 4/15/15 at 4:40 pm and w reported to the State agency until t day. The related facility policy and regulatory requirements for immed reporting were reviewed by the administrative and social service s quality improvement purposes. Resident number 99 ¿ The resider at the facility September 15, 2014. circumstances of the Alleged Resid	ntly o obtain owl. The nt e first o recent The airments facility arents. om April valks by nes a ith the d then nood eviewed ed as was not he next the liate taff for t died The	

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CENTE		AND HUMAN SERVICES			OMB NO.	APPROVED 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	E SURVEY PLETED
		245349	B. WING _		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	punched out from r approximately one verbal abuse with F RN- H had docume note in R75's media (7:38 p.m.) which ir 4/24/15. Several sta conference room w raising his [LPN-E] writer came out in a resident [R75] need to her room." The stated, "she can dri to go," and had the about arguing with documented, "Able diffuse the situation services all notified LPN-E was observe conducting a media lower level of the fa LPN-E's personnel had an active Minn had been employed 2015. Review of LI record indicated tha Abuse Protocol trai had not received tra cognitively impaired the incidents of alle had completed onli Prohibition/Resider Alzheimer's client of	his shift at 7:37 p.m., hour after the incident of R75 had occurred. Arted a late entry progress cal record on 4/27/15 at 19:38 included, "Late entry from aff members were in the south when a staff nurse was heard voice towards resident. This attempts to ascertain what the ded. Asked if she wanted to go notes indicated LPN-E had ive herself wherever she wants in made some comments her. RN-H further to redirect the resident and be and some comments her. RN-H further to redirect the resident and be and some comments her. RN-H further to redirect the resident and be and some comments her. RN-H further to redirect the resident and be and some comments her. RN-H further to redirect the resident and be action pass on a unit in the action	F 2;	 25 incident during the morning 2014 not being submitted ur afternoon was reviewed by t management staff for continimprovement purposes. Resident number 98 ¿ The rat the facility December 29, circumstances regarding the delay in reporting a bruise to administrator and State ager reviewed by the management continuing quality improvem The Social Worker will moni compliance by auditing incid timely and appropriate notific administrator and State ager next three months. If noncor noted, additional auditing an be done. Compliance will be during the September Qualit and Assurance Committee of meeting and ongoing. 	til the he uing quality resident died 2014. The 48-hour the ncy were nt staff for ent purposes. tor ent reports for cation of the ncies for the npliance is d training will reviewed by Assessment	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	heard [LPN-E] yellin NA-C then explained hallway near the nu- re-direct R75, "We but then she [R75] question and he sta her again. We were from the situation." remember what LP screaming about. During an interview indicated she could that had taken plac However, she state heard LPN-E yelling remember what hat confrontation but st least 10 minutes. N been interviewed al aware she could re agency. During an interview DON was asked to regarding the imme allegations of abuse residents to the adr and any interventio other residents, or a incident. The DON the allegation involve because he had be physical abuse alle R65. During a follow-up intervention	age 24 g in the back nursing area, we ng and screaming at [R75]." ed she had walked up the urse's station and was able to started walking away with her asked him [LPN-E] another arted yelling and screaming at e finally able to remove her NA-C stated she could not 'N-E was yelling and ' on 6/11/15 at 6:00 p.m., NA-E d not recall all of the events be the evening of 4/24/15. ed she could remember she'd g at R75. NA-E could not d been said during the tated the yelling had lasted at JA-E also stated she had never bout the incident and was not port abuse to the State ' on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the e between LPN-E and the ministrator or State agency, ns taken to protect R75 or any investigation of the abuse confirmed he had not reported ving R75 to the State agency een more focused on the gation between LPN-E and	F 2	225			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245349	B. WING		06/ [.]	17/2015
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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	after dinner which w stated, "[LPN-E] wa him down the hallw yelling was all about was in her face yell the wheelchair, and confused than usua after the incident R man was yelling at me?" until she wen besides the repeate anxious and quiet t went to bed. NA-C who she'd told about The facility COMPL REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4// investigation for R6 4/25/15 by LPN-J a regarding [LPN-E] a would be asked to a a medication admir grabbed the water pi with it. He grabbed back on cart. She ti to hit him with it, no	was around 6:30 p.m. NA-C as really loud, we could hear vay. We went to see what the ut, when we went up there, he ling at her, she was sitting in d I think [R75] was more al." NA-C further explained that 75 had kept repeating, "That me, why was he yelling at t to bed. NA-C stated that ed question, R75 had been he rest of the night until she stated she could not recall ut the incident. LAINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but	F 225			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245349	B. WING	i		06/	17/2015
NAME OF I	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	closed fist at which asked [R65] to leav [LPN-E] left shortly Another witness sta physical abuse of F RN-H on 4/25/15 at the interaction betw 4/24/15 as I was or [RN-A]. I was inforr gotten in [LPN-E] ha around [R65] until 1 [NA-C] is filling out was reported to my aware of this situati had occurred by [Lf soon as able." R65's quarterly MD R65 had a BIMS so cognitive impairment R65's care plan ver demonstrated beha interventions includ receptive when she her using calm, dire Review of R65's me certified nurse pract requested to condu 4/28/15. The CNP' documented as an physical assault." T included: "Charge r patient was physica	65] went as if to hit him with a time I got between them and e the area which she did. after that." atement regarding the alleged 65 had been documented by nd included: "I did not witness veen [LPN-E] and [R65] on n phone [symbol for with] ned by [LPN-J] that [R65] had face but was unaware of the ad put his arm and hand 1 p.m. on 4/24/15. CNA an incident report stating it self and [LPN-H]. I was made on 4 hours [symbol for after] it PN-B]. I reported incident as S dated 4/28/15, indicated core of 4 indicating severe nt. ified the resident wioral problems and ed: "She is much more has familiar staff working with ext approach." edical record indicated a titioner (CNP)-D had been ct an assessment of R65 on	F	225			

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CENTERS FOR MEDICARE & MEDICAID SERVICES		0	FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTF A. BUILDING	RUCTION	(X3) DATE SURVEY COMPLETED	
245349	B. WING		06/17/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE		
STEWARTVILLE CARE CENTER		TH STREET NORTHEAST TVILLE, MN 55976		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPP DEFICIENCY)	BE COMPLETION	
 F 225 Continued From page 27 the patient had been placed in a chokehold per another eyewitness. No bruising was noted after the event. Patient had no difficulty breathing, no laryngeal edema, stridor, or tracheal deviation. Director of nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from assault. Patient has no evidence of any trauma to her neck. There is no bruising, abrasions, evidence of finger prints on her neck or shoulder area. She has some resolving bruising noted on her left hand and nurse reported that she has some mild soft tissue swelling of her left thumb after the incident which has now resolved" An additional entry written by CNP-D on 4/28/15 at 6:18 p.m. included, " Charge nurse has informed me that patient [R65] had an altercation with a staff nurse on April 24, 2015. The patient was agitated and attempted to throw her water pitcher at the nurse. The nurse reached and grabbed the patient's wrist with one hand and the water pitcher with the other hand. There was some mild swelling noted on the patient's left thumb web space with a bruise occurring after the incident. Today she has some resolving bruising noted on her left hand and no further swelling of her left thumb after the incident which has now resolved. Director of Nursing and Social Services were notified. A vulnerable adult form was filled with Olmsted County. Nursing is requesting that patient be evaluated for any potential injury from the altercation. She [R65] denies all complaints of pain today. Patient has no evidence of any trauma to her body with no bruising or abrasions, or change in her functional status" 	F 225			

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245349	B. WING		06/ [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWARTVILLE CARE CENTER				20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 225	Continued From pa	ige 28	F 225			
		was notified of the abuse which occurred on 4/24/15 after				
	evening meal, DON	I stated staff had placed a his home phone following the				
	incident but he did r	not listen to it until the next				
	come to the facility	4/25/15) at which time he had to follow-up on the incident.				
		was the responsibility of the assistant director of nursing,				
	administrator, or so	cial worker to submit any e reports to the State				
	designated agency.	•				
		d the incident report, a to the State agency (Office of				
	Health Facility Com	plaints-OHFC), and all				
	According to the rep	regarding these allegations. port submitted to OHFC, the				
		t immediately reported. The al abuse against R65 had				
	been reported the c	day after it had occurred, d been no report of the				
	allegation of verbal	abuse against R75. The				
	had been submitted	cated an investigative report d to the OHFC on 4/29/15. The				
		N-E's account of the physical ever, it lacked other eye				
	witness accounts of	f the physical abuse testimony all of the witnesses. Despite				
	the CNP's assessm	nent, the investigative report				
		suffered no harm or injury. eported swelling in the hand				
		bed by LPN-E during abuse P-D's physical and functional				
	assessment comple	eted on 4/28/15 verified there				
		and bruising of R65's left wrist. eport also documented a				
	personal improvem	ent plan for LPN-E that				
	included education	re., vulnerable adult and				

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245349	B. WING _			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	report to the board to another unit. During an interview 9:45 a.m., the DON counseling, educati behaviors especiall might become agita the DON stated the followed-up with LP incidents for R75 ar employed by the fac documentation as tw was working on in r improvement, comp dementia related be personal stress in a abuse situations fro RN-A was interview she verified that LP Protocol training du received training on impaired residents incidents of alleged RN-A versified that had been required to related to Abuse Prr rights/Caring for the Following the surve reporting of these a verbal/physical abu the State agency (C abuse R75 had sus was made on 6/12/	ollow up with social worker, of nursing, and reassignment with the DON on 6/12/15 at I stated LPN-E receiving on on dealing with difficult y residents with dementia who ated and combative. However, e social worker who had PN-E after the alleged abuse nd R65 was no longer cility and there was no o what improvements LPN-E regards to his performance betence of handling agitated ehaviors, or dealing with a healthy manner to prevent or redeveloping. Wed on 6/12/15, at 11:57 a.m. PN-E had received initial Abuse wing orientation, but had not n dealing with cognitively since hire until after the abuse on 4/24/15. following the incidents, LPN-E to complete online education ohibition/Resident e Alzheimer's client on 4/28/15.	F 22	25			
	was made on 6/12/ plan of correction for						

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY IPLETED
		245349	B. WING			06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR		ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	situation existed. The the State agency in [Minnesota Departr to this writer's atten [LPN-E] was yelling was initially reporte another demented the main focus of the information in regar investigation of R65 was also agitated a responding to re-din at resident due to h [R75] and her contri initially combined be nurse [LPN-E] into now reporting this p separate incident On 6/16/15 all staff facility's abuse prot from the assistant of reported for work. read the packet of if abuse protocol. The policies entitled: Baa Investigations, In-S Resident Abuse, Re Symptoms of Abuse Reporting/Investigation Agencies and Othe Reporting Suspecter Rape, Vulnerable A Misappropriation of Investigating Unexp	he incident description sent to cluded: "During routine MDH ment of Health], it was brought tition that on 4/24/15, staff LPN pat resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was nat OHFC report and rds to R75 was to support the 5. During this incident [R75] and following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a ." received a copy of the ocol packet (forms undated) director of nursing as they The staff were requested to information in regards to be packet included specific to the section of Screening ervice Training, Preventing ecognizing Signs and e/Neglect, ting Resident s. Abuse and/or Neglect oction of Residents During h, Report Abuse to State r Entities/Individuals, ed Cases and/or Incidents of dult Reporting of Alleged Residents Personal Property,	F2	225			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE 245349 B. WING 06/17/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST	(X3) DATE SURVEY COMPLETED	
120 FOURTH STREET NORTHEAST	7/2015	
120 FOURTH STREET NORTHEAST		
STEWARTVILLE CARE CENTER STEWARTVILLE, MN 55976		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE	
F 225 Continued From page 31 F 225 In addition the packet of information included undated facility policies for Visitation, Quality of Life-Dignity, Employee In-Service Program, Six Keys to Resident Loyalty, Indicators of Abuse, and Indicators of Neglect. F 225 Interviews were conducted by survey staff with direct care staff, activities staff, pool nursing staff, and supervisory nursing from day and evening shifts on 6/16/15 between 2:20 p.m. and 2:40 p.m. to verify receipt of education prior to starting their shifts. Each staff person interviewed verified they had received a packet of information and were in the process of reading it as detailed in the facility's IJ removal plan. RN-A was interviewed on 6/16/17 at 2:45 p.m RN-A stated all staff were provided training as described as they reported to work. Facility policies related to Abuse Prohibition were reviewed. An undated policy entitled Reporting/Investigating Resident Accidents/incidents involving residents must be reported to the director of nursing services and immediately to the administratorAll accidents/incidents involving residents will be thoroughly investigated by management and the findings of such investigation included: "All reports of resident abuse or neglets shall be promptly and thoroughly investigated." An undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	substantiated incide immediately to the <i>J</i> reported to approprint The immediate jeop was removed on 6/ determined the faci- plan for removal in as they reported to policies related to a and reporting prior residents. In additional been developed and complaince with face non-compliance removed Additional incidents policies for reporting The facility had sub- agency on 4/16/15, au- indicated, "[R64] we next to [F-B]As he out of the chair, [F- forearm" R64's diagnosis, ac- admission record d with functional decl quarterly Minimum 3/25/15, identified F impairment and rec- from one person fo (ADL)'s.	ents of abuse will be reported Administrator and promptly riate State agencies." pardy that began on 4/24/15, (16/15 when it could be ility had operationalized their regards to educating all staff work regarding the facility's abuse, neglect, maltreatment to allowing staff to work with on, montioring systems had id initiated to ensure continued cility protocols. However, mained.	F 22	25		

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/-	17/2015
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTE	ĒR			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	 4/15/15, included a observed resident a recliner chair. [F-B] back down. Nurse r voice. Nurse then o the chair control outhim on the right fore called social service Administrator notifie. Although the facility member striking R6 not reported to the S day, 4/16/15. Although R99 susta origin on 8/19/14, th administrator and s immediately. An incident report for the State agency or had occurred the pr was found in her row assistant]. Another floor[R99] was staher left arm. She did sent to the Emerged preliminary results i fracture of her left s R99's record was readmission record da diagnoses including osteoporosis. The cidentified R99 as ha impairment and requirement and require	note from 4:30 p.m., "Nurse attempting to get out of a attempted to tell resident to sit noted agitation in the [F-B ' s] observed resident's [F-B] pull t of resident's hand and hit earmNurse immediately es to evaluate the situation. ed as well." was aware of the family 64 on 4/15/15, the incident was State agency until the next ained an injury of unknown he facility failed to ensure the tate agency were notified or R99 had been submitted to n 8/20/14 for an incident that revious day, "Res [resident] om by a CNA [certified nursing residentwas lying on the anding in the room guarding d complain of pain. Res was ncy Room for xray and indicate resident sustained a	F	225			

Facility ID: 00429

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING _			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	8/19/14 at 10:30 a.1 resident's room and friend was laying or was standing guard her left arm and sai was made to do RC A review of the faci Investigation Repor administrator and d indicated the incide administrator on "8, reported to the Stat "8/20/14, PM." Although the facility of unknown origin of ensure the adminis notified immediately The facility had sub agency on 8/12/14, cares [8/10/14] resi large, purple-black forearm extending finger. Has no histo Resident is not able Alzheimer's disease R98's record was re admission record d resident had diagno Alzheimer's disease 11/18/14, identified impairment and wa all activities of daily	sing progress notes dated m. included, "CNA entered this d noted that this resident's in the floor and this resident ding her left armShe guards id owe-owe when any attempt DM [range of motion]." http://s Alleged Resident Abuse t Form, signed by the lirector of nursing on 8/20/14, on thad been reported to the /20/14, AM," and had been the licensing agency on was aware R98 had bruising on 8/10/14, the facility failed to trator and state agency were y. omitted a report to the State which included: "During AM dent was discovered to have a bruise on the left medial along the left thumb and index ory of recent trauma, or falls. to say what happened due to e." eviewed and the resident ated 12/5/08 indicated the oses including: dementia and e. A quarterly MDS dated R98 had severe cognitive s totally dependent on staff for	F 22	25			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	 8/10/14 at 12:40 p.r cares were being p bruise was noted of extending along the measuring 23.5 cm 4.5 cm in width. The indicated R98's left edematous, and the as R98 cried out wh A Skin Integrity Everindicated the purplis medial forearm externational forearm externation and index finger, was swollen. A review of the facill Investigation Report the administrator ar 8/15/14, included: "resident's L [left] metrauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impaction intra-articular extern investigative report administrator had n incident until 8/12/1 During interview on stated administrator. The adminis	m., indicated while morning rovided, a large, purple-black n R98's left medial forearm, e left thumb and index finger, (centimeters) in length, and e progress notes also hand and fingers were e area appeared to be tender, nen arm was moved. ents Report dated 8/10/14, sh-black bruise on R98's left ending to the side of the thumb as mildly painful and was lity's Alleged Resident Abuse t Form, signed as reviewed by nd director of nursing on Unexplained bruise noted on edial forearm. No history of comfort noted with gentle [nurse practitioner] on ordered. Results show a ted fracture distal radius with ision and osteoporosis" The also indicated the not been notified of the 8/10/14		225			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 01/26/2016 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DA	ATE SURVEY DMPLETED
		245349	B. WING		0	6/17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR	TVILLE CARE CENTI	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 F 226 SS=F	DON confirmed he to be submitted imm have a system prob Review of the facilit Abuse to State Age Entities/Individuals alleged/suspected v incident of mistreatu unknown source, or be immediately report to proper State age 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle and misappropriatio	te agency as required. The was aware the reports needed nediately and stated, "We ilem." y's undated policy Reporting ncies and Other included: "Should an violation or substantiated ment, neglect, injuries of an r abuse be suspected, it must ported to the administrator and ncies." P/IMPLMENT ETC POLICIES velop and implement written ures that prohibit ect, and abuse of residents on of resident property.		225		6/17/15
	by: Based on interview facility failed to impl policies and proced reporting of alleged administrator and S resident/s from ong thorough investigati abuse/neglect for 5 R64, R99, R98) wh prohibition. This had	NT is not met as evidenced and document review, the ement their abuse prohibition ures related to immediate abuse/neglect to the tate agency, protecting oing abuse, and completing a on following an allegation of of 26 residents (R75, R65, o were reviewed for abuse d the potential to affect all 68 residing in the facility.			Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. The Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply wit all applicable state and feral regulatory requirements and constitutes the facility; allegation of compliance.	S S IS h

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		AND HUMAN SERVICES		0	FORM APPRO MB NO. 0938-	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		245349	B. WING		06/17/201	5
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	ETIO
F 226	Continued From pa	lge 37	F 22	6		
	undated Policy and to Abuse Prohibition The undated policy and Symptoms of A personnel are to re of abuse/neglect to director of nursing s the Administrator." and symptoms of a promptly. The proce physical abuse, sig and signs/symptom abuse/neglect. The undated policy Reporting/Investiga Accidents/Incidents involving residents of nursing services administrator." Th "all accidents/incide thoroughly investiga findings of such inv by the Director of N The undated policy Investigation read, or neglect shall be investigate the incid report daily to the a the investigation. T that employees tha resident abuse wou	entitled Recognizing Signs Abuse/Neglect read, "all port any signs and symptoms their supervisor or to the services and immediately to The procedure directed signs buse should be reported edure lists signs of actual ns of actual physical neglect, as of psychological entitled tring Resident a read, "All accidents/incidents must be report to the director and immediately to the e procedure directed staff that ents involving residents will be ated by management and the restigation will be kept on file		Stewartville Care Center has devel and implemented written policies a procedures that prohibit mistreatmeneglect, and abuse of residents an misappropriation of resident proper policies and procedures address the seven following components: screet training, prevention, identification, investigation, protection, and reporting/response. Stewartville Care Center staff record and respects each resident is right free from maltreatment, neglect, ar misappropriation of property and do that is within its control to prevent so occurrences. The facility staff 1) ide residents who are at risk for abuse neglect, and/or misappropriation of property 2) develops intervention strategies to prevent occurrences a routinely reassesses the effectiven the interventions. During the mandatory staff training 14, 15 and 16, 2015, the facility por related to abuse prevention/ report were reviewed and the staff were instructed on 1) the types of incidents/accidents that need to be immediately reported to the administrative/supervisory staff 2) procedures for notifying the admini staff and the appropriate government agencies of the incident/accident at necessary documentation related t incidents/accidents.	ent, d rty. The he ening, gnizes to be nd oes all such entifies , and 3) ess of July licies ing strative ent nd 3)	

Facility ID: 00429

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		& MEDICAID SERVICES			<u>MB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245349	B. WING		06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226	results of the invest the administrator. The undated policy Residents During A facility will protect re- investigations of ab procedure directed investigations, emp abuse would be rea- duties or put on lea- reassigned to non-r- assignments would building which the r procedure read, "SI abuse occurred, ap notified." The undated policy State Agencies and read, "All alleged/su substantiated incide immediately to the A reported to appropri- procedure directed alleged/suspected v- incident of mistreat unknown source, o- must be immediate and to proper state Social Services 2. N Health/OHFC. B. V	entitled Protection of buse Investigation read, "Our esidents from harm during use allegations." The that during abuse loyees accused of resident assigned to nonresident care ve; and that if employees were resident care duties, such not be in any part of the resident frequents. The hould the results indicate that propriate authorities will be entitled Reporting Abuse to I Other Entities/Individuals uspected violations and all ents of abuse will be reported Administrator and promptly riate state agencies. The "A. Should an violation or substantiated ment, neglect, injuries of r abuse to be suspected. It ly reported to the administrator agencies 1. Olmsted County Minnesota Department of /erbal/written notices to the	F 22	6 Resident number 75 ¿ The resider cognitive deficits and self-propels wheelchair around the facility. Shoccasional negative interactions weresidents which require staff interves She does not recall the incident frago 15. The social worker will meet resident weekly for four weeks and monthly for six months to assess and behavior. The resident frequer visits the Social Worker ¿s office that a piece of candy from the candy by care plan was reviewed and found appropriate. Resident number 65 ¿ The resider for the facility. She has had not altercations with staff; her usual resistiveness to bathing continues resident has severe cognitive impart and believes that she works at the and is a care taker for her grandpase. She does not recall the incident frago 15. The social worker frequently interacts with the resident as she with the resident weekly for four weeks and the social service office several times and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and behavior. The care plan was resident weekly for four weeks and we found appropriate.	her e has vith other vention. om April with the d then mood otly o obtain owl. The d first o recent . The airments e facility arents. om April y walks by nes a vith the d then mood	
	following the incide administrator, or his internal investigatio working days of the	I be made immediately nt if possibleC. The s/her designee, will submit n report to OHFC website 5 e occurrence of the incident." to have been verbally abused		Residents number 64 ¿ The allege abuse by the resident¿s spouse w observed 4/15/15 at 4:40 p.m. and not reported to the State agency u next day. The related facility policy the regulatory requirements for im	vas d was Intil the / and	

Facility ID: 00429

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	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245349	B. WING			06/1	17/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWA	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 226	by licensed practica The incident was n administrator or de was R75 protected thorough investigat A facility COMPLAI REGARDING an E completed by nursi The concern includ [LPN-E's first name CONCERN: Upon residents from sup heard a lot of comr that the nurse [LPN at resident [R75]. V her room, she [R75] question and he sta That's when we rer situation" During an interview DON was asked fo immediate reportin administrator, OHF protect R75 from fu residents and a tho abuse incident. Not stated he did not re separately but was in regards to the pf DON stated he was abuse incident with physical abuse of F	al nurse (LPN)-E on 4/24/15. ot immediately reported to the signated State agency, nor following this incident, or a tion completed. NT/CONCERN FORM MPLOYEE had been ng assistant (NA)-C 4/25/15. led: "EMPLOYEE NAME: e] "COMPLAINT OR returning from bringing per co-worker [NA-E] and I notion/screaming. We noticed J-E] was yelling and screaming Ve tried to take her [R75] to 6] asked [LPN-E] another arted yelling at her again. moved her [R75] from the of the verbal abuse to the C, and interventions taken to urther abuse as well as other brough investigation of the ne was provided and the DON eport this incident with R75 with the report sent to OHFC hysical abuse to R65. Then the amere focused on the physical n R65 at the time. Again the R65 occurred shortly after the 5 by LPN-E on 4/24/25 after is LPN-E was passing	F 2	226	reporting were reviewed by the administrative and social service st continued quality improvement pur Resident number 99 ¿ The residen at the facility September 15, 2014. circumstances of the Alleged Resid Abuse Investigation Report Form for incident during the morning of Augu 2014 not being submitted until the afternoon was reviewed by the management staff for continuing qu improvement purposes. Resident number 98 ¿ The residen at the facility December 29, 2014. circumstances regarding a bruise observed 8/10/14 and the 48-hour reporting the bruise to the administ and State agency were reviewed by management staff for continuing qu improvement purposes. The Social Worker will monitor compliance by auditing incident rep timely and appropriate notification of administrator and State agencies for next three months. If noncompliance noted, additional auditing and traini be done. Compliance will be review during the September Quality Asse and Assurance Committee meeting ongoing.	poses. t died The dent or an ust 20, uality t died The delay in rator y the uality ports for of the or the ce is ng will ved ssment	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245349	B. WING	ì		06/ ⁻	17/2015
NAME OF !	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAF	RTVILLE CARE CENT	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	record until two day "Several staff mem conference room w voice towards resid indicated notificatio services, however of notifications were g The DON reported OHFC and to the C 6/12/15 after the su facility an immediat abuse existed. R65 had been verb LPN-E on 4/24/15 h immediately reported OHFC. The facility COMPL REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4/2 investigation for R6 LPN-J read, "On Fr staff potluck,He [medication admin a grabbed the water pitch	ys later on 4/27/15 and read, bers were in the south when a staff nurse heard raising dent." The progress note also on of DON, ADON, and Social did not indicate when the given. the verbal abuse of R75 to the Common Entry Point (CEP) on urvey team had informed the te jeopardy (IJ) related to bally and physically abused by however, this was not ed to the administrator or AINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but	F	226			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING _		06/	17/2015
NAME OF !	PROVIDER OR SUPPLIER	<u>.</u>		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAF	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	on cart. She then ra him with it, not sure dropped it but it fell up and [R65] went a fist at which time I g [R65] to leave the a shortly after that." The facility provided submission report to of Health Facility Co investigative notes. complaint, the alleg to R65 had not bee had been reported R64 had an allegati family (F) member however, it was not until the next day. The facility submitte on 4/16/15 indicatin being hit on the fore around 4:40 p.m. "[chair next to [F-A] up and out of the ch forearm" A review of the nurs 4/15/15, at 4:30 p.n resident attempting [F-A] attempted to the Nurse noted agitation then observed reside right forearmNurs services to evaluate notified as well."	age 41 aised up her walker, as if to hit e if he knocked it down or she on the floor. [LPN-E] picked it as if to hit him with a closed got between them and asked area which she did. [LPN-E] left d the incident report, to the State agency (the Office omplaints-OHFC), and all . According to the OHFC gation of verbal/physical abuse en not immediately reported but the following day 4/25/15. ion of physical abuse by a which occurred on 4/15/15 t reported to the State agency ed a report to the State agency ng a nurse witnessed R64 earm by [F-A] on 4/15/15, [R64] was sitting in a reclining As he was attempting to get hair, [F-A] struck him on the sing progress notes, dated n., included, "Nurse observed to get out of a recliner chair. tell resident to sit back down. on in the [F-A]'s voice. Nurse dent's [F-A] pull the chair ent's hand and hit him on the se immediately called social e the situation. Administrator	F 22			

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		AND HUMAN SERVICES				FORM	: 01/26/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING			06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER		-	OURTH STREET NORTHEAST VARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 42 the facility did not immediately	F 22	6			
		to the state agency.					
	agency on 8/20/14 found in her room b assistant]. Another floor [R99] was st her left arm. She di sent to the Emerge	or R99, submitted to the State indicated, "Res [resident] was by a CNA [certified nursing residentwas lying on the tanding in the room guarding id complain of pain. Res was ncy Room for xray and indicate resident sustained a shoulder"					
	8/19/14 at 10:30 a.r this resident's room friend was laying or was standing guard her left arm and sai	sing progress notes dated m., included: "CNA entered n and noted that this resident's n the floor and this resident ding her left armShe guards id owe-owe when any attempt DM [range of motion]."					
	Investigation Repor administrator and d indicated the incide reported to the adm	lity's Alleged Resident Abuse rt Form, signed by the lirector of nursing on 8/20/14, ent from 8/19/14 had first been ninistrator on "8/20/14, AM," ntly been reported to the State on "8/20/14, PM."					
	forearm which was however, this was r State agency or the	have a large bruise on her left found to be a fracture not immediately reported to the e administrator as directed by policy and procedure.					
	on 8/12/14, which ir [8/10/14] resident w	ed a report to the state agency ncluded: "During AM cares vas discovered to have a large, on the left medial forearm					

Facility ID: 00429

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING		06/ [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 226	Continued From parextending along the Has no history of relis not able to say we Alzheimer's Diseas A review of the nurse 8/10/14 at 12:40 p. reares were being p bruise was noted of extending along the measuring 23.5 cm 4.5 cm in width. Alse and fingers were early appeared to be tend arm was moved. A review of the facil Investigation Report administrator and dincluded: "Unexplait L [left] medial forea area. Discomfort no motion]. Seen by N 8-12-14, and x-ray comminuted impact intra-articular extent included, the admir 8/12/14. Although the facility of unknown origin administrative staff.	age 43 e left thumb and index finger. ecent trauma, or falls. Resident that happened due to te." sing progress notes dated m., indicated while morning rovided, a large, purple-black n R98's left medial forearm, e left thumb and index finger, in (centimeters) in length, and so included, R98's left hand dematous, and the area der, as R98 cried out when lity's Alleged Resident Abuse rt Form, signed by the lirector of nursing on 8/15/14, ined bruise noted on residents rm. No history of trauma to obed with gentle ROM [range of IP [nurse practitioner] on ordered. Results show a ted fracture distal radius with histon and osteoporosis" Also nistrator was not notified until y was aware R98 had bruising on 8/10/14, the facility failed to trator and State agency were y. n 6/11/15, at 9:34 a.m. the (DON) indicated the were to submit reports to the	TAG F 226	DEFICIENCY)	RIATE	
	State agency and s	stated, "Other staff can, but I ne." DON stated he carried a				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUE DINC	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NOMBER: A. BUILDING	
245349 B. WING	06/17/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	
STEWARTVILLE CARE CENTER 120 FOURTH STREET NORT STEWARTVILLE, MN 559	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	V OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE IENCY)
F 226 Continued From page 44 F 226 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." F 247 F 247 ROOM/ROOMMATE CHANGE F 247 A resident has the right to receive notice before the resident's room or roommate in the facility is changed. F 247 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide prior notice of a new roommate for 2 of 2 residents (R11, R40) reviewed for admission, transfer, and discharge. The staff at Stewartv respect the residents notice before the resi roommate share serveral temporary roommates after her family member (F)-Q died. R11 stated she knew she would have to get one, but was not told in advance of them coming. R11 The staff is sensitive move or change of roommate bits/he are than taken into ad	<i>v</i> ille Care Center <i>i</i> , right to receive ident; s room or d. to the trauma that a commate causes attempt to be as ossible. The resident er preferences which ccount when of rooms or iming of such sident is moved at the explanation of the is provided. The opportunity to see the

Facility ID: 00429

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245349	B. WING _			06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 247	Continued From pa	-	F 2	47			
	mental status (BIM anemia, depression SS progress note of survey done recent concerns. R11 said getting a new room which was some tir On 6/09/2015 2:54 shared R11 had ne shared room on 4/2 roommate moved i verified she was un new roommate not for the above dates roommate. R40 was asked abor recently on 6/08/20 he had a new room	n on the brief interview for S). R11's diagnoses included n and diabetes mellitus. dated 3/26/15 read, "Resident dy and I followed up on that she was not informed of mate after her [F-Q] died, me ago. I apologized for that" p.m. social services (SS)-A w roommates move into her 29/14, 7/24/14 and her current n on 8/18/14. The SS-A hable to find documentation of ifications in the medical record a she received a new			move, and meet the new roommate whe possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another perso into the room. On June 24, 2015, the facility is medical record consultant met with the social worker who started employment June 22 2015 to discuss the required resident notifications including the resident is right to be informed prior to changes in rooms and roommates. A copy of the related regulations was provided for reference. The updated policy addressing new		
	a new roommate. R40's quarterly Mir 4/21/15 indicated F on a score of fifteen diagnoses included anemia. On 6/09/2015 2:54 have a recent room room on 5/20/14. T unable to find docu new roommate in F stated when a resid a new roommate m	advance he would be getting himum Data Set (MDS) dated A40 had intact cognition based in on the BIMS. R40's I Parkinson's disease and p.m. SS-A verified R40 did mate move into his shared he SS-A verified she was mentation of notification of a R40's medical record. SS-A dent in the facility will be having hove in, the social service ented a progress note in the			roommate notification was reviewed the social service staff. The situatio regarding lack of documentation ve that residents number 11 and 40 we notified of new roommates was also reviewed as part of the ongoing cor education and quality improvement procedures/process. The administrator will monitor comp weekly for four weeks through staff interview and record review verifyin residents received notice prior to re a new roommate. If noncompliance noted, additional monitoring and sta training will be done. Compliance w reviewed at the September Quality	n rifying ere b tinuing bliance g that ceiving is aff	

Facility ID: 00429

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SUR	
		245349	B. WING	_			
NAME OF I	PROVIDER OR SUPPLIER	210010			REET ADDRESS, CITY, STATE, ZIP CODE	06/17/20	115
STEWAF	TVILLE CARE CENTI	ER		12	0 FOURTH STREET NORTHEAST FEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COM	(X5) PLETIC DATE
F 247	received notification roommate move in A facility policy was notification of havin a shared room, but facility.	record the resident had in they would be having a new to their shared room. requested on resident g a new roommate move in to was not received from the rISION OF MEDICALLY	F 24 F 25		Assessment and Assurance Committee quarterly meeting.	7/27	7/15
SS=D	The facility must proservices to attain or	ovide medically-related social r maintain the highest I, mental, and psychosocial					
	by: Based on observat review the facility fa (R26) psychosocial reported ongoing co and neighbor reside and resulted in moor routines to avoid co had not had interve behaviors towards f Findings include: R26 was admitted to according to the fac R26's quarterly Min 4/15/15 indicated mission was independent with During an interview	NT is not met as evidenced ion, interview, and record iled to ensure 1 of 1 resident needs were met when R26 oncerns with roommate (R68) ent (R1) that had not resolved dification of R26's daily onfrontation. Also R68 and R1 ntions developed in regards to R26. o the facility on 4/29/14 cility admission record. imum Data Set (MDS) dated o cognitive impairment and ith activities of daily living. on 6/9/15, at 8:26 a.m. in an tion "Have there been any			The Stewartville Care Center interdisciplinary team is committed to provide residents with comprehensive services to attain or maintain their highe practicable physical, mental and psychosocial well-being. The interdisciplinary team address residents concerns with the goal to provide social supports, physical care, and an enriche environment that meet the residents; individual needs and preferences. All residents are routinely assessed by qualified staff, including a social worker assure they are effectively coping with changes in health status, admission to the facility, current family relationships, etc. Medically-related social service needs a	ż d to he	

Facility ID: 00429

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TATE				TIDU		MB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 250	Continued From pa	-	F 2	50			
	other resident," R26 to say that she had quarterly MDS date impairment) who liv shared the same bat to say that her room moderate cognitive quarterly MDS date yelled and cursed a over the past month door locked so she residents room to u occasions. R26 the daily told her when watch television, wh when and how to ge seemed to want mo for her things. In residents hat make you you what to do?" R bossy, I feel like I'm her, she's always ter reported it to the so concerns, I'm not su is still hereI'm not my concerns. They less just got used to anything more." R2 very loud at night an stated she did not w had been treated (in	ns with a roommate or any 5 stated, "Yes.!" R26 went on problems with R1 (R1's d 4/8/15 shows no cognitive ed in the adjacent room and athroom as R26. R26 went on mate (R68 who had impairment according to the d 5/6/15). R26 stated R1 had t her on multiple occasions ns and kept R26's bathroom had to go into the other nlock it to use on several n said her roommate (R68) to go to bed, when she could here to put her walker, and et dressed. R26 stated R68 ore space in the shared room sponse to the question, "How if feel to have someone telling 26 stated, "She is kinda walking on eggshells around elling me what to do. I've cial worker about the ure if the same social worker aware if she followed up with come and go fast. I more or o it, so I don't even say 6 further stated R68 snored nd kept her awake often. R26 want to be treated the way she in reference to both R1 and			 identified through completion of resassessment tools, quality indicator results, review of the medical historinformation from family/direct care and social service interviews/evaluations/be that impact the resident is psychos well-being; referrals are made to thattending physician or other clinical practitioners as indicated. The interdisciplinary team will review significant resident incidents, behavioral conferences. A nursing communication will be developed to alert the seconferences. A nursing communication will be developed to alert the seconferences. A nursing staff will be appropriate follow up. During the mandatory meetings Juli 15 and 16, 2015, the nursing staff will be haviors/conditions/statements ar family concerns that indicate need interventions to meet the resident incident inci	report 'y, staff, ations. haviors ocial e viors, kly tion ocial ilitate y 14, vill be ed to be nd/or for s eds. orker 015 to	
	because nothing ha help from the facility not to deal with it, h with it.	expecting anything to change ad changed despite asking for y. R26 stated it would be nice owever had learned to deal nterview on 6/10/15, at. 1:30			discuss her concerns regarding her roommate. The social worker noted ¿(resident) states she gets along f with roommate neither roomma wants to move or have the other roommate move out.¿ The residen	d, ine ite	

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	RS FOR MEDICARE		()(0)		OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		SURVEY PLETED
		245349	B. WING _		06 /1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ	
STEWAF	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 250	Continued From pa	ge 48	F 25	50		
	well with problems y roommate (R68) ar me now It still hur frustrated, I'm not a to the question, "Ho stated, "When [R68 know what I did, bu dealt with the neigh a bedside commod confrontation with. I preferred to use the commode. R26 sta bit without one of th am doing." R26 sta change several mo worker had not eve stated, "I am tired nothing changes, se learned to deal with R26's care plan pro- read, "Has occasion her roommate and common bathroom support with is as n included intervention to resident and enc concerns and feelin explanation of diffic resolve the concern Social service prog "[R26] came to soc on 12/5/14 seeking other residents. She particularly cruel on that hurt was comp whom she has prev	with neighbor (R1) and Id said, "I try not to let it bother ts my feelings, and I'm child you know." In response by do you deal with it?" R26 I] starts in, I just say "I don't t I'm sorry." R26 stated she bor bathroom issue by having e at night to avoid R26 stated she would e bathroom vs. the bed side ted, "I can't even move a little rem questioning me on what I ated she had asked for a room nths ago, stated the social r come in to talk with her. R26 of reporting the concerns and o what's the point? I've just it." vided by the facility on 6/11/15 hal difficulties in dealing with others that she share a with but seeks out staff eeded. Care plan also n of "provide on-going support ourage resident to share her ig." The care plan lacked ulties and interventions to	F 23	 bathroom. The social worker is resident on July 10, 2015. The note states, ¿Visited with resider egarding her roommate. She things have been `straightened that they are getting along tog room. Resident reports that so though she has enough room belongings. She also reports to independently uses the comm of the adjoining bathroom in hight, and she is satisfied with arrangement. Resident report satisfied with her current room not like to switch at this time. Are resident is care plan was revisued and updated to addr regarding shared space. The visited by the social worker Ju and reported that ¿things are She declined an offer for a root and stated she is happy with froom. To monitor compliance, the R record consultant will random records twice monthly for two randomly thereafter for appropriod documentation and follow up medically-related psychosocia noncompliance is noted, additi auditing and staff training will Compliance will be reviewed a surance Committee quarter 	e social work dent reports that d out¿, and ether in the he feels as for all of her that she ode instead er room at this s that she is n and would , The ewed and sidents e been ress issues resident was ly 14, 2015 going well.¿ om change her current N medical y audit months and oriate to al issues. If tional be done. during the nt and	

Facility ID: 00429

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349		ING		PRINTED: 01/26/201 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		243543	B. Willia			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	for her. She is adjust avoid confrontation, place in the hallway with the supervisors pros and cons of a advised to speak w thoughts on the inter- place." The progress services would con- support and indicate social worker would R1's progress notes of follow-up perform R26 shared with so care plan read, "Do argumentative disp- residents. She has other" The care p confrontational with multiple room chan- reflect the issue wit R1. R68's progress note of follow-up perform R26. R68's care pla concerns, intervent roommate. R26's progress note monitoring had bee voiced concerns at further mention of the the resident brough again in her care co- Care conference pr read, "We provided about her interaction next door neighbor,	ars to be making things worse sting her bathroom routines to The comments also take ys and dining room. I spoke is about the situation and the room change and was ith roommate to ascertain her eractions reported to be taken is note further indicated social tinue to offer emotional ed if problem persisted the d attempt mediation. Is were reviewed, no evidence hed related to the concerns of cial worker on 12/5/14. R1's es present with an osition at times with other verbal behaviors toward lan also indicated she is residents and has had ges. The care plan did not h the shared bathroom with es were reviewed, no evidence hed related to the concerns of an did not reflect or identify any ions, or problems with es did not reflect follow-up or n performed as a result of the 12/5/15 meeting and no he issues until 4/29/15 when t the same concerns forward	F2	250			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING	ì		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	RTVILLE CARE CENT	EB			120 FOURTH STREET NORTHEAST		
SILWA					STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 250	same but she had g She tends to accor spoken up." No follow-up was e medical record as a concerns and issue conference. During an interview licensed social wor staff reported to he to the residents and going on" however, aware of the conce documented in the the facility had turn the last year. LSW had been assigned LSW stated a griew During an interview director of nursing not been filled. DON have been filled ou with roommate (R6 he had not been av roommate despite the medical record should have been f his expectation wor a situation for a pos worker involvemen During an interview family member (F)- roommate and neig roommate had alwa telling [R26] what to TV off, when to go things I hear it. [F	grown to better deal with them. nmodate others but also has vident in R26's, R1's, or R68's a result of the again mentioned es at the 4/29/15 care on 6/9/15, at 3:30 p.m. ker (LSW) explained nursing r with any concerns pertaining d "every morning I see what is LSW stated she was not orns despite the concerns medical record. LSW stated ed over three social workers in stated the social worker who to that wing, left in May 2015. vance had not been filed. on 6/9/15, at 4:00 p.m. (DON) stated a grievance had N stated a grievance should t in regards to R26's concern (8) and neighbor (R1). Stated ware of the problem with the the concerns documented in . DON stated the concerns followed up on. DON indicated uld have been re-evaluation of ssible room change and social	F	250			

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PRINTED: 01/26/2016

		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	really frustrated, ev Every time I call she her roommate. I ha [R26's] mood but I of stated had not been ongoing issues con neighbor. F-A expla R26, but had been handling the proble think [R26] is happy think she is happy. were not around sh of life. [R26] was ne know if she was up deal with it and dea a while before she want to create wave thing and mind her During an interview nursing assistant (N judgmental of peop R26's bathroom con the door so R26 ca NA-K further stated the roommate, "[R6 line [which divides r goand they have [R26] was shutting explained R26 was concerns, "she wou bad." NA-K explain resident concerns, social worker. During an interview licensed practical n not been aware of t roommate despite t	eryday there is something. e expresses frustration with ven't noticed a big change is do know she is frustrated." F-A n notified by the facility of the accrning the roommate or the ained had offered assistance to told by R26 she had been ms. To the question, "Do you y?" F-A stated, "No, I don't I would think if those people would have a better quality ever a person who let people set about something. She will al with it until it explodes, takes reports anything. She doesn't es, she wants to just do her	F 25			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP		PRINTED: 01/26/2010 FORM APPROVED OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		à		PLETED
		245349	B. WING	·		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	commode had beer compromise to the During an interview NA-E stated "[R1] tr aggressiveshe ter a little more vulnera [R26] about the bat about letting people wants things a certa sideR26 will just a seen her get upset of person that holds tries to get along wi keeps to herself." I where R68 had atte down and had to be During an interview NA-A stated had wi R26 and R1 in the p of the problems with bathroom with R26. An undated policy of grievances/complaints r writing." "The admir responsibility of grie investigation to Soc a grievance and/or investigate the allegore report of such findir (5) working days of and/or complaint. An undated facility p Clinical Record rea Records of each re about personal and related to the reside	w about it." LPN-J stated a n placed in R26's as a bathroom problem with R1. on 6/11/15, at 3:13 p.m., ends to be more nds to pick on people that are ableshe really goes after hroomand is very vocal e know." NA-E stated, "[R68] ain way even if it's on [R26's] shrug it off and ignore it. I have and frustrated. She's the type is things in. She is the type that th everyone, she is quiet and NA-E explained an example, empted to take R26's calendar e redirected. on 6/11/15, at 3:35 p.m., tnessed arguments between past. Stated everybody knew h R1 not wanting to share the	F2	250			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 01/26/2016 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245349	B. WING		06	/17/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR	TVILLE CARE CENTI	ĒR			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 250		-	F 2	50		
F 279 SS=D	in the clinical record 483.20(d), 483.20(k COMPREHENSIVE	(1) DEVELOP	F 2	79		7/17/15
		he results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, and	velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment).				
	by: Based on record refailed to develop a of mood, behavior and of 5 residents (R45) medications. Findings include: R45 was admitted to to the facility admised	NT is not met as evidenced eview and interview, the facility comprehensive care plan for d psychotropic drug use for 1) who received psychotropic o the facility 6/12/14 according sion record with diagnoses as not limited to bipolar			Stewartville Care Center uses the results of the comprehensive assessment to develop, review and revise the resident;s comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident;s needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the	

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Facility ID: 00429

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			0938-039 SURVEY
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:				COMP	LETED
		245349	B. WING			06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 279	Continued From pa	ge 54	F 2	79			
	R45's significant ch (MDS) dated 3/12/1 depression with a F interview) score of 9 bipolar disorder, an care rejection, and when compared to addition, the MDS in antipsychotic and a Care Area Assessm based off of the MD that required a plan as a result of the MD mood state, behavi psychotropic drug u R45's physician orc 6/10/15 included Le medication) 20 milli Wellbutrin XL (antic mg per day, Depak used as a mood stat day, and Zyprexa (a at bedtime. R45's care plan did included individualiz the triggered care a and psychotropic drug was identified; the c in regards to care a depression and ass During an interview MDS coordinator lic (LPN)-G verified the	ange Minimum Data Set 5 indicated moderate PHQ-9 (resident mood 9, identified diagnosis of d indicated behavior status, wondering had worsened previous assessment. In ndicated R45 received ntidepressant medications. nent (CAA's) were triggered DS assessment information of care. The CAA's triggered DS assessment included: oral symptoms, and			resident¿s highest practicable physical mental, and psychosocial well-being a 3) recognizes the residents¿ right to refuse cares/services. The care plan and MDS (minimum dat set) related policies/procedures and th staff responsibilities for development a revision of the comprehensive plans o care were reviewed and revised. Withis seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed During the mandatory meetings on Jun 14, 15, and 16, 2015, the licensed nur staff were 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents¿ care plan must be current at all times and 3) instructed that care plans must address the MDS triggered care areas that are assessed as needing to be included in plan of care. The care plan for resident number 45 reviewed and revised to more comprehensively address the triggered care areas of ¿behavioral symptoms¿ ¿psychotropic drug use.¿ The care are ignificant change MDS with an assessment reference date of June 10	and tta he and of iin d. une rsing ms ss en the was ed cea ie	
	state, behavioral sy drug use should ha plan. The facility policy M	imptoms, and psychotropic ve been included in the care linimum Data Set/Resident col/Care Planning that was not			2015; the resident reported only two symptoms indicative of depressed mo As part of the quarterly care conference process, the interdisciplinary team rev	ood. ce	

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		AND HUMAN SERVICES	FORM APPROVED OMB NO. 0938-0391						
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			0938-0391 SURVEY			
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:		NG		PLETED			
		245349	B. WING		06/-	17/2015			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	17/2013			
STEWAR	TVILLE CARE CENTI	FR		120 FOURTH STREET NORTHEAST					
0.1				STEWARTVILLE, MN 55976					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 279	Continued From pa dated does not reflet 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incapacitated under participate in planni changes in care and A comprehensive car within 7 days after t comprehensive asso interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative and revised by a tea each assessment.	ge 55 ect current standards. 0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or	F 27	79 the care plans for completeness, accuracy, and relevancy. For the ne quarter, the MDS Coordinator will co focused audits on the care plans for residents who trigger the care areas behavior symptoms, mood state and psychotropic drug use. If noncompli is noted, additional monitoring will b done. Compliance will be reviewed the September Quality Assessment Assurance Committee quarterly me	ext onduct s of d ance e during and	7/17/15			
	legal representative and revised by a tea each assessment.	e; and periodically reviewed am of qualified persons after							

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PRINTED: 01/26/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1			APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245349	B. WING		06/-	17/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
Based on obs review, the fac care to include for 1 of 1 resid Findings includ R65 received I supplement wa amount consu amount consu to determine if in stabilizing w (RD)-B's progr staff to monito monitoring foo indicated on the R65's care pla	Based on observative review, the facility for a care to include the for 1 of 1 resident (Findings include: R65 received house supplement was give amount consumed amount consumed to determine if there in stabilizing weight (RD)-B's progress in staff to monitor intamonitoring food and indicated on the care R65's care plan data	tion, interview and document ailed to revised the plan of dietician's recommendations R65) reviewed. e supplement however, the ven to the resident but the was not documented and the of meals was not documented e was an effective intervention t loss. The registered dietician note dated 5/7/15, indicated ike; although, The need for d supplement intake was not	F 28	Stewartville Care Center staff rou develop comprehensive care plan seven days after the completion of comprehensive assessment. Car are prepared by an interdisciplina which includes the attending phys registered nurse with responsibili resident, and other appropriate st Professional disciplines work tog plan and provide necessary servi enhance the residents; functiona and quality of life. The residents a family/legal representative are encouraged to participate in the of planning process and care confect the greatest extent possible. Care are routinely reviewed and revise team of qualified persons after ea quarterly assessment and more of necessary.	ns within of the e plans iry team, sician, a ty for the taff. ether to ces to al abilities and their care rences to e plans d by a ach	
	needs observing if needed." The lister provide setup for re apply condiments, of An interview on 06/ certified dietary ma wanders up and do weight this month, of The nurses gave he times a day. No or she eats at a meal track now. An interview on 06/ registered dietician her meals well and times a day. R65 est	she is eating and assist as d approach is "One staff to each meal-open containers, cut foods and butter breads." (10/2015 at 12:32 a.m. with nager (CDM) who said R65 wn the hallway. She lost currently she weighs 114 lbs. er a house supplement three he keeps track of how much but they will start keeping (11/2015, on 8:48 a.m. (RD)-B said R65 consumes takes a supplement three xpels a lot of energy by in May 2015, she had a weight		During mandatory meetings July and 16, 2015, the care staff will b reinstructed on the facility; s polic care plan reviews and updates 2) informed of the regulatory require that the residents; care plans be at all times and 3) reminded of th importance of facilitating accurate plans by communicating resident care/condition changes to the departmental supervisors, includi dietary department, in a timely may The Nutritional Care Plan Policy reviewed and revised. The Nutriti Supplement Policy was updated to address tracking the amount of supplement consumed other than time. The procedure for tracking	e 1) sies for ement current e care ng the anner. was onal to	

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245349	B. WING _		06/17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • •
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTIO
F 280	her weight loss is 1 "She is on the risk months now." RD- looked at what the supplement. An interview on 06/ registered nurse (R house supplement one records how m A policy dated 4/20 "Nursing service	 past six months. As of today 1.6% for the past six months. list and being monitored for B continued to say I haven't nurses are signing out for her (11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said no nuch is consumed. 00, entitled supplements read, record intake of supplement will be 	F 28	 supplement intake at meal time vertice and found appropriate. The care plan of resident number reflects the May 12, 2015 physic order for an increase in the nutrit supplement from four ounces on day to three times per day due howeight loss related to increased expenditure from physical activity (continually walks throughout the of the facility). The nutrition care updated to include offering the resinacks and finger foods as the rewalks about the facility. The reside weight will be monitored on a more basis and her supplement intake monitored on a daily basis. The resident currently weighs 11 pounds showing a slight weight gain pounds in 2013, she gained an a fifteen pounds last year after an period of reduced physical activity to non weight bearing status whil recovering from a fracture. After successful recovery and resump her usual physical activity, she is back to her September 1, 2013 be weight of 114.0 pounds. The reside care plan will continue to be revise least quarterly and revised as ne The physician/nurse practitioner consultant dietitian will be inform further weight loss. 	r 65 ian;s ional ce per er recent calorie / first floor plan was esident dent;s onthly will be 4.8 gain in the punds 30, of ten ddition extended y related e a tion of now paseline dent;s ewed at eded. and

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		AND HUMAN SERVICES			FO	RM A	01/26/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		245349	B. WING			06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR		F 3		To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplements are appropriately addressed. The dietary manager will monitor intake tracking of liquid supplements ordered for increased calories/protein weekly for four weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly meeting.		7/16/15
	by: Based on observat review, the facility fichange in condition R2) with chronic pat Findings include: R11 was interviewe and stated she had shoulders. R11 stat	NT is not met as evidenced tion, interview and record ailed to reassess pain after a a for 2 of 2 residents (R11 & in. ed on 06/09/2015 at 10:26 a.m. lots of pain in her back and ted she took a lot of pain d stated that she currently had			Stewartville Care Center provides each resident with the necessary care and services to attain or maintain the highes practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident¿s condition indicates. The	st ne	

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		AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO.	APPROVE 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			E SURVEY PLETED	
		245349	B. WING			06 /1	7/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	•		
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECT RRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 309	(scale 0 no pain and she used Ultram (pashe had "out-grown needed to have bot repaired, but did no 6/11/15 at 6:15 p.m her chair and eating shoulder pain was a nothing was being of R11 was admitted to diagnoses listed on included: chronic pa Physician orders of Ultram twice a day a scheduled Tylenol e scheduled Narco (n times a day. On 3/18/15 the physio otherwise continues to her arthritis in he failed all conservatif Assessment read,"of shoulder - quite syn The quarterly Minim R11 had a BIMS (br of 15 or no cognitive R11 had rated her p assessment for pain The care area asse 7/9/14 indicated the at 10 in the shoulder received scheduled	t she would rate almost a 10 d 10 severe pain). Stated that ain medication), but felt that it." R11 stated that she h rotator cuffs (shoulders) t want surgery again. On . R11 was observed sitting in g her meal. R11 stated her at a 10 out of 10 and that done for her. o the facility in 2006 and had the physician orders that ain and osteoarthrosis. 6/11/15 included: scheduled and as needed (PRN), extra strength twice a day, arcotic medication) three sician note read, "Patient s to have symptoms in regards r shoulders. Patient also has ve therapies for that." degenerative joint disease -	F 3	resident¿s co effective pain When a resid of care is dev routinely reev necessary ba analgesic ord assessments In April 2015, revised the p procedures to Sheet tool to precipitating f pharmacolog interventions 2) the Compr Form to evalu pain, type of interventions residents who indicator on t Quality Meas the Pain Flow Comprehens completed. B pain assessm plan will be re physician/nur regarding on care plan will reflect curren nonpharmaco alleviate pain	the facility reviewed ain assessment poli- o include 1) a Pain F track the location, ir factors for pain as w ical and nonpharma and their effectiven- rehensive Pain Asse- uate the resident is pain, causes of pain to alleviate pain. The o flagged the pain q he MDS 3.0 Reside- ure Report were first v Sheet and the ive Assessment For based on findings fro- nent, the pain mana eassessed. The rse practitioner will b going pain symptom be revised as nece- at pharmacological a ological intervention	valuated. in, a plan ed, d as n ¿s d and cies and clow ntensity, rell as icological ess and ssment history of a, and re uality nt Level t to have m om the gement be notified s. The ssary to nd s to July 14, iff will be		

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				יסוד			0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY PLETED	
		245349	B. WING		<u>-</u>	06/17/2015		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ige 60	F 3	309				
		x [symptoms] of pain limiting			tracking forms. The MDS Coordina continue to initiate the pain flow she and complete pain assessments for	eets		
date pair the ass Dur licer usu war The	The Pain Interview section for MDS 3.0 section J. dated 3/23/15 noted the resident had occasional pain, that made it hard to sleep, and would rate the pain at a 8 out of 10. No further				residents flagging the pain indicato Resident Level Quality Measure Re and for residents who report a sign increase in pain or have uncontrolle	r on the eport ificant ed pain.		
		on 6/11/15 at 6:24 p.m.			The physician/nurse practitioner wi notified and reassessments will be as indicated.			
	usually had pain an wanted her to have The facility would a	urse (LPN)-J stated R11 of that the physician only pain medications for control. Iso provide warm packs. hought the pain was related to			Resident number 2 ¿ A 5-day pain tracking tool has been initiated to h identify pain frequency, location, in and effectiveness of interventions.	tensity		
	the "gas" (air in bow	vels) in the abdomen and that e a rectal tube and anti-gas			reassessment of the pain manager plan will be done after a review of t collected data, resident/staff interv and review of the nurses and	nent he		
	regards to a pain as stated that she was assessments and a	on 6/11/15 at 11:30 a.m. in ssessment for R11, RN-F s just starting to do pain any pain assessment would be art. However, none was			physician/nurse practitioner progre notes. (The physician was called Ju 2015 regarding uncontrolled pain a visit is scheduled for June 14, 2015	uly 7, .nd a		
	located nor provide				During the June 23, 2015 MDS pai interview, the resident indicated he was a ¿ten¿ on a ten-point intensit	r pain		
	stated that her legs her bottom was sor of the Hoyer mecha level was up to 7 ou	ached. R2 also stated that re because of cancer and use anical lift. R2 stated her pain ut of 10 scale, but currently did			but stated her pain did not impact h sleep or day-to-day activities. Evalu of the resident; s pain and the effectiveness of the interventions w	ier Jation Vill be		
	indicated R2 stated	ce on 4/7/15 documentation I she was having more pain			ongoing. The care plan will continu updated to reflect the resident is pa symptoms and interventions.	ain		
		ntation of 4/20/15 noted right Iling for R2. The nursing			Resident number 11 ¿ A 5-day pair tracking tool has been initiated to h identify pain frequency, location, in and effectiveness of interventions.	elp tensity		

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING		06/ [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER		20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309		/20/15 through 6/11/15 did not	F 309	reassessment of the pain manager plan will be done after a review of t		
	The annual MDS da BIMS of 14 or no co section was left und	ument the resident having pain. e annual MDS dated 12/23/14 indicated a IS of 14 or no cognitive impairment, the pain tion was left undone. The quarterly MDS ed 3/24/15 indicated a pain intensity of 7 on a		collected data, resident/staff interv and a review of the nurses; and physician/nurse practitioner progres notes (a physician visit is scheduled June 14, 2015). The June 9, 2015 s service note states, ; reports that h mood is improving and she is starti	iews, ss d for social er	
	had pain due to gou in back and should On 06/11/2015 at 1 coordinator, stated	ed 4/6/15 indicate the resident ut and generalized pain usually ers. 11:30 a.m. RN-F, the MDS that she was just starting to do and had not done any for R2		feel better.¿ The July 10, 2015 nurs note states, ¿No complaint of pain evening shift.¿ The pain managem plan of care will be reviewed and up as necessary. Evaluation of the resident¿s pain and the effectivene the interventions will be ongoing.	se;s on ent pdated	
F 323 SS=E	Pain Evaluation Propain was to be reas condition indicates On 06/11/2015 at 1 nursing stated he wassessments be co assessments had r 483.25(h) FREE OF HAZARDS/SUPER	2:03 p.m. the director of yould expect pain ompleted and that he knew the not been done for R2. F ACCIDENT VISION/DEVICES	F 323	Compliance will be monitored by th Assistant Director of Nurses/Design auditing for pain assessments for residents flagging the indicator mea pain on the Monthly Resident Level Quality Measure Report for three m If noncompliance is noted, addition auditing and staff training will be do Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly me	nee by asuring I nonths. al one. d	7/17/15
	environment remain as is possible; and	nsure that the resident ns as free of accident hazards each resident receives on and assistance devices to				

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		AND HUMAN SERVICES			FOF	D: 01/26/2016 MAPPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245349	B. WING	à	c	6/17/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From pa	ge 62	F	323		
	by: Based on observat review, the facility fall risk following m (R73) reviewed for to ensure a safe en hazards in the facili R46, R26) reviewed Findings include: R73 was observed in his wheelchair at shoulders rounded table. At 5:27 p.m. independently whee table using his feet foot rests were in th using his feet in bet The quarterly Minin 3/3/15 was reviewe interview of mental loss, no history of re assist with bed mot limit assistance with of traumatic brain in The incident report 5/19/15 at 6:10 p.m R73 on his knees a the chair. No injurie notes of 5/20/15 inc needs of waiting for	on 6/8/15 at 5:22 p.m. sitting the dining room table with his and leaning forward to the R73 was observed to el the chair away from the on the floor. The wheelchair ne down position with R73 tween the foot rests. num Data Set (MDS) dated d. R73 had a BIMS (brief status) of 12 or mild cognitive ecent falls, required extensive pility and transfer, required n mobility, and had a diagnosis			Stewartville Care Center has policies ar procedures to ensure that the residents, environment remains safe and as free o accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develo a plan of care addressing safety issues with interventions to enhance mobility ar promote safety. The policies and procedures related to assessing the resident¿s risk of falls we reviewed and found appropriate. An assessment of fall risk will continue to be done at the time of admission. A reassessment will be done as part the quarterly interdisciplinary assessment process and whenever there is a change in the resident¿s behavior, physical condition, and/or mental function. The resident¿s care plan is modified as necessary to ensure maximum safety ar minimal risk of injury. During the mandatory meetings July 14, 15, and 16, 2015, the licensed nurses an direct care staff were reinstructed on 1) the importance of providing a safe environment for residents 2) the procedures for completing the fall risk assessments and 3) the need to assess the resident¿s need for safety	ind nd

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		AND HUMAN SERVICES				01/26/201 APPROVE 0938-039		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY PLETED		
		245349	B. WING		06/	17/2015		
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE			
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 323	6:;26 p.m. R73 was his wheelchair into is independent in the effective. He is aler ability to take the pip placed next to residen his wheelchair. The facility had cont 4/10/15 at 9:06 a.m assistant had heard room, and found the the bed. The residen bed. R73 reported injury found. No fur were found. The resident's care was a fall risk and the normal risk for falls resulting in hip frac- impaired cognition.	of 5/22/15 read On 5/20/15 at a found self transferring from bed after supper. As resident he facility and able to visit his ng on his own, pin alarm is not t and oriented x 3 and has the n alarm off. Floor alarm dent's bed to prevent further t self transferring in and out of npleted a fall report dated b. The report noted the nursing d a noise while in the next e resident on the floor next to ent attempted put himself to hitting his buttock, but no ther incidents after 8/14/14 plan dated 3/17/15 noted R73 hat R73 was a greater than secondary to recent fall ture, history of falls, mildly Interventions include: strips and one staff to assist with all	F 3	 23 interventions/devices and rocevaluate their effectiveness. nonskid safety strips have be and either removed or replace Environmental Director will in monitoring of the condition on nonskid safety strips as part safety inspection process. Resident number 73 - The read and history of falls were reads to the resident ¿s recent increant and impulsiveness (related the traumatic brain injury and fra ataxic gait) a physical therapp made. After therapy goals ar nursing restorative program implemented to maintain strea ambulation abilities and redu falls. The care plan was review updated accordingly. Resident number 68 ¿ The unonskid safety strips was reads safety strips will continue to be front of the resident ¿s bed. If have been installed. Resident number 46 ¿ The unonskid safety strips will continue to be front of the resident and the streads and the strips will continue to be front of the resident and the streads and the strips will continue to be front of the resident and the streads and the streads and the streads and the strips was reads and the strips will continue to be front of the resident and the streads and the	All the floor een inspected ced. The nclude f floor of the routine esident is risk seessed. Due ease in falls o a history of acture hip with by referral was re met, a will be ength and uce the risk of ewed and use of floor assessed; be used in New strips			
	Assessment were of 2/11/15 were found scored a 17 or moo Physical therapist (6/11/15 at 3:15 p.m had told her that no call light on and that	dated 8/14/15, 11/11/14, in the chart. All assessments		nonskid safety strips was rea The strips were removed. Resident number 26, The us nonskid safety strips was rea The strips were removed. The Director of Nurses/desig monitor compliance with pos	assessed. se of floor assessed. gnee will			

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	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245349	B. WING _			17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
STEWA	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 323	therapy in May 2016 been notified of furt R73 was at a high f impulsiveness, histe history of TBI that at that R73 could work balance safety and needed contact gua control. The director of nurs 6/11/15 at 5:28 p.m probably be reasse determine the caus physical therapy bu for need. LACK OF SECURE PREVENT SLIPPIN During an environm at 10:14 a.m. with n the following was of R68's room had am originally stuck to th were loose and fray the middle of the re front of the resident trip hazard and agro removed and said, he preceded to rem the floor. R68's care plan dat greater than norma diagnosis of dizzine history of falls." Th	4. PT-A stated she had not her falls. PT-A added that all risk related to his ory of hip fracture and medical ffects his balance. PT-A felt with physical therapy for sequency. PT-A stated R73 ard and lacked impulse sing (DON) was interviewed on . and stated R73 should ssed following the falls to e. DON added R73 could use t needed to first be assessed ED SAFETY STRIPS TO IG: mental facility tour on 06/11/15, naintenance manager (MM)-A	F 32	assessments through record weekly for four weeks. If nor noted, additional monitoring education will be done. Com reviewed at the September O Assessment and Assurance quarterly meeting.	ncompliance is and staff pliance will be Quality	

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	-	AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 323	Continued From pa it is free from hazar obstacles, items on R46's room had no floor which were cu located in front of h agreed they were a R46's care plan dat "comprehensive a than normal risk for increasing her fall r the care plan read, make sure it is free lighting, obstacles, R26's room had thr attached to the floo about two feet in fro and the ends of the curling up. MM-A a hazard. R26's care plan dat "comprehensive a than normal risk for failure and use of d approach listed on the environment to hazards such as po on the floor" On 06/11/15, at 10:	age 65 rds such as poor lighting, in the floor" In slip strips adhered to her irrling up around the edges her recliner. MM-A again a trip hazard. Ited 5/12/15, read, assessment reveals a greater if falls is on an antipsychotic risk." The approach listed on "Review the environment to a from hazards such as poor items on the floor" ree non skid strips which were or in the middle of the room ont of the bed. The middle ese strips were loose and again agreed they were a trip	F 323	DEFICIENCY)	'HIAI E	DATE
	document his findin also said he does n during these inspec	ngs from the inspection. MM-A not document any concerns				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		245349	B. WING	i		06/ ⁻	17/2015		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
STEWAR	TVILLE CARE CENTI	ĒR	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 323 F 325 SS=D	director of nursing (there is any docume but did agree the pe be removed. A safety policy was 483.25(i) MAINTAIN UNLESS UNAVOID Based on a residen assessment, the fac resident - (1) Maintains accep status, such as bod unless the resident demonstrates that t	DON) said he was not aware entation of safety inspections eeling non slip strips need to requested but not received. NUTRITION STATUS OABLE t's comprehensive cility must ensure that a otable parameters of nutritional y weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a		323			7/17/15		
	by: Based on observat review, the facility fa reassess nutritiona (R65) reviewed for Findings include: R65 had a significa 180 days however, were not monitored maintain or gain we R65 received house	nt weight loss over the past interventions put in place /assessed if appropriate to			Based on a resident¿s comprehens assessment, Stewartville Care Cent ensures that a resident maintains acceptable parameters of nutritional status, such as body weight and pro levels, unless the resident¿s clinical condition demonstrates that this is n possible. Therapeutic diets are prov as ordered by the physician. The Nutritional Care Plan Policy was reviewed and revised. The Nutritional Supplement Policy was updated to address tracking the amount of	er I Itein Iot ided			

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245349	B. WING			06/17/2015	
NAME OF	PROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 325	actual amount cons and the amount co documented to det effective intervention R65's most recent progress note date reflected weight los past 30 days, six p and 16 pounds (12 Weight loss is sign progress notes aut dietician (RD)-B da resident's current v weight loss of 9.2 p Recommended ho to four ounces three further weight loss monitor intake. R65 was admitted dementia and CVA A quarterly Minimu 4/28/15, identified l eating. the MDS a problems with coug complaints of diffic significant change required supervision or cueing during m 128 pounds at that Nursing progress r 6/9/15, with the onl	sumed was not documented nsumed of meals was not ermine if there was an on in stabilizing weight loss. weight from dietary resident d 6/10/2015, was 114 pounds so of four pounds (3.4 percent) ounds (5 percent) past 90 days .3 percent) past 180 days. ificant past 180 days. Dietary hored by the registered ted 5/7/15, indicated veight is 118 pounds and ago, 130 pounds. This reflects bercent in 6 months. use supplement be increased the times a day to prevent was initiated and staff to with diagnoses that included . (cerebral vascular accident). m Data Set (MDS) dated R65 required supervision for lso indicated R65 had no ghing/choking during meals or ult chewing or swallowing. The MDS dated 1/28/15, R65 on, oversight, encouragement eal time. R65's weight was time.	F 3	25	supplement consumed other than time. A designated space was add the medication administration reco (MAR) to document the amount of supplement consumed. The proce tracking supplement intake at mea was reviewed and found appropria The staff will continue to assess th residents; condition, including nut needs/risks upon admission, when significant change occurs, and no than once every three months. Bas the (re)assessments, a compreher plan of care is developed that addr the resident; s nutritional needs an preferences; the plan is reviewed a quarterly and revised as necessary The policies and procedures for re and monitoring weights have been reviewed and found appropriate. Residents are weighed monthly an often as ordered by the physician of requested by the dietitian or licens nurse. If the resident has had nontherapeutic weight changes or risk of weight loss, the resident; s nutritional status is reassessed and attending physician and consultant dietitian are notified. During mandatory meetings July 1 and 16, 2015, the licensed nurses instructed on the changes in proce related to recording the amount of supplement consumed on the MAR	ed to rd dure for l time te. e ritional a less sed on nsive resses id at least /. cording is at d the t t t t t t t t t t t t t t t t t t	

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		AND HUMAN SERVICES	r		ON		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245349	B. WING			06 /1	7/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 20 FOURTH STREET NORTHEAST		
STEWAF	TVILLE CARE CENT	ER		1 S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 325	offered food, fluic No other mention of available nor was a Medication flow she until 6/10/15, indicate house supplement consumed. The mu until 5/31/15, indicate supplement with th 6/1/15. Monthly we sheet during this per A dietary nutritional indicated no concernutritional assessm time. Computer generate received from certif weight on 1/5/15, 1 lbs; 3/1/15, 120.4 I 118.4 lbs; 6/1/15, 1 Observations on 6/ 75% of her meal. ate 50% of meal. An interview on 06/ CDM who said R65 hallway. She lost w weighs 114 lbs. Th supplement three ti	Andering up and down halls. Is and activity as appropriate." of food consumed was any provided when requested. The R65 given four ounces of but no monitoring of amount edication flow sheet for 3/1/15, ate once a day house ree times a day started on eights also listed on medication eriod. The assessment dated 1/28/15, rns at that time and no further nents were provided since that ed weight variance report fied dietary manager (CDM), 27.8 pounds (lbs); 2/2/15, 124 bs; 4/1/15, 120 lbs; 5/1/15, 14 lbs. 10/15, at 12:06 p.m. R65 ate On 6/11/15, at 12:03 p.m. R65 (10/2015 at 12:32 a.m. with 5 wanders up and down the veight this month, currently she be nurses give her a house imes a day. However, no one	F 3	325	supplements consumed at meal tim the Food Acceptance Record flow s The care plan of resident number 64 reflects the May 12, 2015 physician order for an increase in the nutrition supplement from four ounces once day to three times per day due her r weight loss related to increased cald expenditure from physical activity (continually walks throughout the fir of the facility). The nutrition care pla updated to include offering the resident weight will be monitored on a month basis and her supplement intake with monitored on a daily basis. The resident currently weighs 114.8 pounds showing a slight weight gain past month. She weighed 105 poun when admitted to the facility April 30 2013. After an initial weight gain of the pounds in 2013, she gained an addit fifteen pounds last year after an extre period of reduced physical activity re to non weight bearing status while recovering from a fracture. After a successful recovery and resumption her usual physical activity, she is no back to her September 1, 2013 bas weight of 114.0 pounds. The resident	sheet. 5 25 al per recent orie st floor an was dent dent tt;s aly ll be n in the ds 0, ten ition ended elated n of ow eline nt;s	
	An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a				care plan will continue to be reviewed least quarterly and revised as needed The physician/nurse practitioner and consultant dietitian will be informed further weight loss.	ed. d	

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		& MEDICAID SERVICES					0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245349	B. WING			06 /-	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 325	supplement three t energy by walking had a weight loss of As of today her we six months. "She is monitored for mon at what the nurses nutritional supplement An interview on 06, registered nurse (F house supplement does not measures anyone record how An interview with F 9:14 a.m. both said much supplement validated they can treatment when it is An interview on 06, director of nurses (expectation is the c of the meal R65 e monitor how much her supplement when R65's care plan da feed self after setu observing if she is The listed approac for reach meal-ope condiments, cut for A undated policy ef preventing ongoing residents in the fact	imes a day. She expels a lot of so much. In May 2015, she of 9.2% for the past six months. ight loss is 11.6% for the past s on the risk list and being ths now" and I haven't looked are signing out for her thent. (11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said s how much is given nor does or much is consumed by R65. RD and CDM on 06/11/2015, at d they have not assessed how the resident consumes. They not assess effectiveness of the	F 3	25	To monitor compliance, the dietary manager will audit the care plans or residents receiving nutritional supplements to assure that supple are appropriately addressed. The of manager will also monitor intake tra of liquid supplements ordered for increased calories/protein weekly f weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be do Compliance will be reviewed at the September Quality Assessment an Assurance Committee quarterly me	ments lietary acking or four one.	

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	ige 70 will be addressed as a risk	F3	325			
	and risk intervention						
	nutritional risk read following conditions Nutritional risk: Low	00, entitled residents at , "Residents with any of the s should be considered at v body weight and increased ent needs related to medical					
F 431 SS=E	"Nursing service r and "Need for an in monitored by nursir 483.60(b), (d), (e) E		F 4	431			7/17/15
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordan professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when					
	facility must store a locked compartmer	State and Federal laws, the III drugs and biologicals in hts under proper temperature it only authorized personnel to keys.					

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					FORM /	APPROVED
	& MEDICAID SERVICES					0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245349	B. WING _			06/1	7/2015
PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	=B					
			S	TEWARTVILLE, MN 55976		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	ge 71	F 4:	31			
permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distril quantity stored is m	I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can					
by: Based on interview facility failed to ensu of used Fentanyl (to medication) patches accepted principles for 2 of 2 residents prescribed Fentany that were outdated accidental use and open date to determ outdated this had th residents including R10, & R71) who u prescription medica Findings include: R7's admission reco diagnosis including sensation with pain R7's physician orde	and document review, the ure safe and secure disposal opical narcotic analgesic s according to currently to prevent potential diversion (R7 & R55)reviewed with I patches. Also medications were not removed to prevent medications opened lacked nine when it would be ne potential to affect several (R29, R4, R65, R42, R46, itilized stock medications and tions.			needs of each resident. The facility contracts with a licensed consultant pharmacist who collaborates with fa staff to coordinate pharmaceutical services and guide the developmen implementation of related procedure ensure the accurate acquiring, rece dispensing, storing and administerir all drugs and biologicals. The pharm has established a system of records receipt and disposition of all control drugs in sufficient detail to enable a accurate reconciliation and determin that drug records are in order and th account of all controlled drugs is maintained and periodically reconcil Drugs and biologicals are labeled in accordance with currently accepted professional principles, and include	acility t and es to iving, ng of nacist s of led n nes nat an led.	
	RS FOR MEDICARE OF DEFICIENCIES OF DEFICIENCIES FOVIDER OR SUPPLIER RTVILLE CARE CENTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L3 Continued From pa The facility must propermanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on interview facility failed to ensu of used Fentanyl (to medication) patches accepted principles for 2 of 2 residents prescribed Fentanyl (to medication) patches open date to detern outdated this had th residents including R10, & R71) who u prescription medica Findings include: R7's admission reco diagnosis including sensation with pain	IDENTIFICATION NUMBER: 245349 PROVIDER OR SUPPLIER STVILLE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 71 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 interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55) reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg. R7's physician orders dated 5/14/15, included an order for Fentanyl patch 25 micrograms (mcg) to	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245349 B. WING PROVIDER OR SUPPLIER TVILLE CARE CENTER B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIT TAG Continued From page 71 F.4 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 interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55) reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg.	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (FCORRECTION (X1) PROVIDER/SUPPLIENCILA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 245349 B. WING 2ROVIDER OR SUPPLIER TVILLE CARE CENTER II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 71 F 431 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 interview and document review, the facility failed to ensure safe and secure disposal of used Fentanyl (topical narcotic analgesic medication) patches according to currently accepted principles to prevent potential diversion for 2 of 2 residents (R7 & R55) reviewed with prescribed Fentanyl patches. Also medications that were outdated were not removed to prevent accidental use and medications opened lacked open date to determine when it would be outdated this had the potential to affect several residents including (R29, R4, R65, R42, R46, R10, & R71) who utilized stock medications and prescription medications. Findings include: R7's admission record dated 4/9/10, indicated diagnosis including lumbago and abnormal sensation with pain in the left leg.	MENT OF HEALTH AND HUMAN SERVICES ON SFOR MEDICARE & MEDICAID SERVICES ON OF DEFICIENCIES (X1) PROVIDERSUPPLERICLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER 245349 INVING TVILLE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, NN 55976 (EACH DEFICIENCY INST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRETX TAG PROVIDERS PULL CONSTRUCTION (EACH CORRECTIVE ACTION PRODUCT (EACH CORRECTIVE ACTION PRODUCT) (EACH CORRECTIVE ACTION PRODUCT) PROVIDERS PULL CORRECTIVE ACTION (EACH CORRECTIVE ACTION PRODUCT) Continued From page 71 F 431 F 431 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 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. Stewartville Care Center provides pharmaceutical services to meet the needs of each resident. The Facility contracts with a licensed consultant pharmaceutical services and guide the developmen implementation of related procedure ensure the accurate acquiring. rece dispensing, storing and administerin all drugs and biologicals. The pharm has established a system of record receipt and disposition of all control drugs in sufficient detalit o enable a accurate reconciliation and determini	MENT OF HEALTH AND HUMAN SERVICES FORM. SF COR MEDICARE & MEDICAID SERVICES OMB NO. or operiorencies FORMEDICARE & MEDICALD SERVICES OMB NO. or operiorencies FORMEDICARE & MEDICALD SERVICES OMB NO. 245349 B WING (rs) MULTIPLE CONSTRUCTION A BUILDING (rs) MULTIPLE CONSTRUCTION A BUILDING (rs) Data STREAT ADDRESS, CITY, STATE, ZIP CODE 067 TVILLE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, NN 55976 067 Continued From page 71 F 431 F 431 F 431 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 storelise to return provide separately locked, per date to determine when it would be outdated this had the potential to affect several accidental use and medications that were outdated were not removed to prevent accidental use and medications. Stewartville Care Center provides pharmaceutical services of the chevelopment and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. The pharmacist has established a system of records of receipt and disposition of all controlled drugs is maintained and periodically records of receipt and disposition and actin the latel to ensure

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		<u>O. 0938-039</u> ATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	Ci	OMPLETED
		245349	B. WING		0	6/17/2015
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAF	TVILLE CARE CENT	ER		20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 431	Continued From pa	ae 72	F 4	31		
	hours, with special and change patch of pain. **When remo and flush down toile R7's Fentanyl patch and stored in the W R55's admission re	instructions, "Apply 1 patch q [every] 72 h [hours] for back ving old patch, wrap in tissue et or put in sharps container.**" nes were administered from /est medication cart.	. 4	51	State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls. The facility provides separately locked and permanently affixed compartments for storage of controlled drugs. The facility utilizes only persons authorized under state requirements to	
		ders dated 4/7/15, included an			administer medications and have access to medication room keys/security codes.	
	transdermally every instruction, "When tissue and flush dor container.**" R55's administered from a medication cart.	batch 50 mcg to be applied 72 hours, with special removing old patch, wrap in wn toilet or put in sharps Fentanyl patches were and stored in the North			Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standard The procedure for disposing of controller substances was reviewed and revised; a Fentanyl patches will now be wrapped in tissue and flushed into the sewer system in the presence of two nurses.	t II
	trained medical ass policy when removi patches, was for tw destruction by putti container attached	on 6/8/15, at 7:15 p.m., sistant (TMA)-A indicated the ng and disposing of Fentanyl o staff to witness the ng them in the sharps to the medication cart, and for Medication Administration			All medication storage areas were checked for discontinued and unlabeled/undated/expired medications and biologicals. The doors securing the sharps containers were inspected; all were found in good order with a function locking mechanism. Any problems with the function/condition of the doors will be	
	medication adminis medication cart, the container attached unlocked and could the content in the s container was easil compartment by sli from the cart. The o several pieces of o	ion on 6/10/15, at 8:40 a.m., of stration from the West e locking door on the sharps to the cart was observed to be l easily be opened, exposing harps container. The sharps y removed from the ding it forward and removing door to the compartment had ld tape on the front and upe on the right side of the			reported to Weber and Judd Pharmacy who owns the carts. During the mandatory meetings July 14, 15, and 17, 2015, the licensed nurses ar trained medication assistants were 1) reinstructed on the procedures for processing discontinued and outdated medications and biologicals including the destruction of used Fentynal patches 2) reminded that the doors securing the	nd

Facility ID: 00429

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	OUNTEOLON		A. BUILDIN	G	COM	
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 431	at 8:50 a.m., the Ea container compartr unlocked and could the sharps contained easily removed from forward. Licensed y the door was unloc could be removed. During a review of at 8:55 a.m., the Ne container compartr unlocked and could the sharps contained easily removed from forward. Registered door was unlocked could be removed. During a review of at 9:10 a.m., the low sharps container co be unlocked and co exposing the sharp container was easil compartment by slit the door was unlocked." During an interview LPN-B stated wher from the residents two staff to witness by either flushing th	age 73 medication storage on 6/10/15, ast medication cart sharps nent door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding it oractical nurse (LPN)-A verified ked and the sharps container medication storage on 6/10/15, orth medication cart sharps nent door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding it d nurse (RN)-B verified the and the sharps container medication storage on 6/10/15, wer level medication cart ompartment door was noted to ould easily be opened, as container. The sharps ly removed from the ding it forward. LPN-L verified ked and stated, "The door	F 43		ication sed and 4) be ed rill audit onthly to ated f ratures. continue to operatures edications. ring the and	

If continuation sheet Page 74 of 86

CENTEI STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349 ER		S 5 1		FORM MB NO. (X3) DATE COM	01/26/2016 APPROVED 0938-0391 E SURVEY PLETED 17/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	sharps container," p container attached medication cart. Wh the sharps container unlocked and the ea container, LPN-B ve and attempted to us unable to get it lock fits, but doesn't turn During an interview director of nursing (that the sharps con- found to be unlocked stated, "They shoul unlocked doors on sharps containers, a containers where us disposed, and this h DON indicated he v for the West medica was cracked, and the A policy was request secure disposal of h provided. A memo v NURSES," dated 12 directed staff to add wrap in tissue and f sharps container," v orders. LACK OF REMOVA MEDICATIONS OR WHEN OPENED T WILL BE OUTDATE During an observati p.m. of the north me	bointing to the sharps to the side of the West nen asked about the door to er compartment being ase of removing the sharps erified the door was unlocked se a key to lock it, but was ed. LPN-B stated, "This key to lock the door." on 6/10/15, at 10:05 a.m., DON) stated he was aware tainer compartments were ed during observation, and d be locked." DON verified the the compartments holding the allowed access to the sharps sed Fentanyl patches were had the potential for diversion. would be ordering a new door ation cart because the door ne doors were to be locked. Sted for ensuring safe and Fentanyl patches, and was not written by DON, to "ALL 2/16/13, was provided, and d, "When removing old patch, lush down toilet or put in when receiving Fentanyl patch AL OF OUTDATED TO DATE MEDICATIONS O DETERMINE WHEN IT	F 2	431			

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING		06/ ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	novolin regular was ml multidose vile ou stated the policy ind 28 days after being An observation on 0 first floor medication found and verified k R29's coumadin (a pill outdated for 4-1 R4's coumadin 1 m 4-15; R4's coumadin 2.5 for 4/15; R65's jantoven (a b pills outdated for 4- R65's jantoven 1 m 4-15; R42's jantoven 1 m 4-15; R46's jantoven 1 m 4-15; R10's jantoven 2.5 4-15; In the medication re multidose influenza vials which were ou expiration of 5-15. A multidose tubercu but not dated to det outdated. On the west medic p.m. with LPN-B for (ketam 2%) with ma 5-25-15. An interview on 6/1	s outdated for 5-2-15, lantus 10 utdated for 5-1-15. RN-B dicated multidose vials expire opened. 06/10/2015, at 2:56 p.m. of the n room and the following was by RN-G: blood thinner) 1 mg one (1) 5; ng one (1) pill outdated for mg two (2) pills out outdated blood thinner) 2.5 mg six (6)	F 431			

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245349	B. WING	i		06 / [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	refrigerator tempera monitored. A undated policy en biologicals indicated after opening" and ⁻ Dispose of 30 days 483.65 INFECTION SPREAD, LINENS The facility must ess Infection Control Pre- safe, sanitary and c to help prevent the of disease and infect (a) Infection Contro The facility must ess Program under white (1) Investigates, con- in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re- prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will tra (3) The facility must	as not aware that the atures were not being htitled labeling/data of drugs & d "Insulin-Dispose of 28 days Tuberculin - Refrigerate - after opening." I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections. ead of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their	F 4	431			7/17/15
		t require staff to wash their rect resident contact for which	l				

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		AND HUMAN SERVICES			FORM	01/26/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · /	E SURVEY PLETED
		245349	B. WING _		06 /-	17/2015
NAME OF F	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 441	 professional practice (c) Linens Personnel must han transport linens so infection. This REQUIREMEN by: Based on observat review the facility fa equipment was disi bactericide sanitize directions for a gluo residents (R29, R1⁻¹ observed. In additic containment of use soiled gloves to pre which could affect s Findings include: R29 had blood gluo 9:22 a.m. registered doing glucose test. monitoring, RN-B w seconds with the St 	Are completion of the spread of a set of the spread of the	F 44	Stewartville Care Center has est and maintains an infection contro program designed to provide a sa sanitary, and comfortable environ the residents and to prevent the development and transmission of and infection. The infection contro program 1) investigates, controls prevents infections in the facility 2 determines the appropriate proce any, that will be implemented (sud isolation) for each resident with a infectious disease and 3) maintai record of incidences of infections tracks any alternative actions take related to infection control. The facility has comprehensive in	I afe, ment for disease ol , and 2) dures, if ch as n and and en	
	the manufacturers of surface to be disinf 2 minutes." R11 was observed 6/10/15 at 6:20 p.m (LPN)-A perform glo	wipe it a while." However, directions say to allow the ected to remain wet for a" full to have glucose test done on licensed practical nurse ucose monitoring for R11. The		control policies and procedures c with the current state and federal control regulations and recomme The policies address the surveilla investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections.	infection ndations. Ince and	
	giucometer was rer	noved from the medication				

Facility ID: 00429

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STATEMEN	OF DEFICIENCIES DF CORRECTION	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245349	B. WING			06/17/2015	
NAME OF	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER			OURTH STREET NORTHEAST /ARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 441	stated the facility a maintained the mo to the medication of of the glucose testi Sani-Cloth wipe to remained in contact one minute and the top of the medicati did not know how I contact with the me directions say to al disinfected to rema R24 had just comp at 6:30 p.m. LPN-E glucometer after us Sani Cloth wipe an the monitor for less finished LPN-B pla of the narcotic boo disinfectant wipe n monitor for 10 to 15 manufacturers dire to be disinfected to minutes." The undated facility Meters Clean and meter, wipe down f registered and app toweletteFollow disinfect the meter The director of nur 6/10/15 at 9:57 a.m follow the direction disinfect the glucor	ctly into R11's room. LPN-A nd not the resident owned and nitors. When LPN-A returned eart following the performance ing, She used the PDI Super clean the meter. The wipe et with the meter for less than a damp monitor was placed on on cart. LPN-A stated that she ong to keep the disinfectant in eter. Again the manufacturers low the surface to be ain wet for a" full 2 minutes." leted glucose test on 6/10/15 8 was observed to clean the se. LPN-B used the PDI Super d left the wipe in contact with s than one minute. When ced the damp monitor on top k. LPN-B stated the eeded to be in contact with the 5 second. Again the ections say to allow the surface o remain wet for a" full 2 y policy entitled Blood Glucose Disinfect read, "To disinfect the the meter with an EPA roved premoistened the product label instructions to ."	F 4	Du ma we sa nu of nu pro Dir dir glu ch ha pro res tas are ad wil at	aring the July 14, 15 and 16, 201 andatory meetings, the licensed are re-instructed on the procedur nitizing glucometer machines; the rsing staff will sign to verify know the glucometer sanitizing procedur sing staff were re-instructed or oper handling of soiled incontine oducts and gloves. The provide the second staff experience of Nurses/designee through ect observation of the nurses; arge nurses will observe for pro- ndling of soiled incontinent oducts/gloves when supervising sident cares and performing others sks/treatments in the resident cares and performing and staff edu I be done. Compliance will be re- the September Quality Assessm surance Committee quarterly m	nurses res for he vledge dure. All h the nt nt ne gh The oer er tre er tre viewed hent and	

Facility ID: 00429

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		AND HUMAN SERVICES & MEDICAID SERVICES		FC	ED: 01/26/2016 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245349	B. WING		06/17/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR		ER		20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC 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 441 F 465 SS=B	SPREAD OF INFEC During an observati soiled incontinent p the bathroom floor f number 39 and 40. During an interview licensed practical m soiled incontinent p stated should have LPN-B donned glow pad in the garbage An undated facility p Morning Care) read and dispose of disp linen appropriately.' P.M. Care (Bedtime clean and tidy." An undated facility p Guidelines instructe in a plastic trash ba 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro- sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility fa comfortable enviror chips of bathroom o (R95, R96, R75, R8	S TO PREVENT THE CTIONS: on on 6/8/15, at 6:18 p.m. a ad and gloves were laying on between resident rooms on 6/8/15, at 6:22 p.m. urse (LPN)-B verified the product on the floor. LPN-B not been left on the floor, es and placed the incontinent bag and removed from room. policy AM Cares (Early , "Leave bedside area clean, osable equipment and soiled ' An undated facility policy e Care) read, Leave room policy Incontinence Care ed, "Discard disposable items g and secure." AL/SANITARY/COMFORTABL	F 441	It is the policy of Stewartville Care Cer to provide a safe, functional, sanitary a comfortable environment for residents, staff, and the public. As part of an ongoing process to provide	nd

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MET			B) DATE S	938-039
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				COMPL	
		245349	B. WING			06/17	/2015
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETIC DATE
F 465	Continued From pa	ige 80	F 46	5			
	the wheelchair use	d by (R1) was soiled.			a pleasant, homelike environment,		
	Findings include:				Stewartville Care Center has a schedu for routine cleaning, repairs, and maintenance of the facility. All staff	le	
		nental facility tour on			members are expected to report		
	· · · - · · ·	4 a.m. with maintenance ne following was observed.			environmental concerns to the appropriate administrative/supervisory staff.	oriate	
		throom door jam near the			An additional maintenance check list h	nas	
		witch in the bathroom had sing the metal which was rusty			been implemented for inspection of resident rooms at the time of discharge		
		register in her room also had			and at least yearly for all long term		
		-A stated the door jams need			residents. The condition of the walls,		
		round the light switch and the sty and need painting.			ceilings, bathroom fixtures, and resider care equipment will be checked. Repa and repainting will be done as needed.	air	
		hroom door jams and around					
		paint chipped and were rusty. ho said he will paint.			The condition of the bathroom door jambs, light switches and heat register will be observed and any areas with	rs	
	75's bathroom door	r frame the paint was chipped.			rust/chipped paint will be repainted. Th	he	
		e chipped area's and the need			door jambs in the bathrooms used by		
	for painting those a	reas.			residents number 95, 96, 75, 87, and 1 have been repainted. The light switche		
		or frame near the bottom was			the bathrooms used by residents numb	ber	
	chipped. MM-A ver metal door frame.	rified the chipped paint on the			95 and 96 have been repainted. The h register in the room used by resident	neat	
					number 96 was repainted. The caulk		
		is soiled, the poles under the			around the toilet in the bathroom used		
		yer of dust, MM-A verified the MM-A stated I suppose its			resident number 11 has been replaced The brown discoloration on the bathroo		
	been a long time si	nce the wheelchair was			floor of resident number 11 is the outlin	ne	
		he process is the staff bring is office with a note asking			of the previous toilet. A new toilet will b installed which has a larger base that	ре	
		sh it. MM-A stated they don't			covers the discolorations. Several staff	ff	
	keep track of which	wheelchairs are washed and			members have checked the bathroom		
		dule for cleaning wheelchairs.			used by resident 11 during varying time of the day and no unpleasant ambient		
	R11's bathroom in I	room had scratched up door			pervasive odors were detected.		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	NO. 0938-03 DATE SURVEY COMPLETED
		245349	B. WING		06/17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2013
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
F 465	jam. The toilet's ca was a yellowish dis the toilet. The bath smell. MM-A agree was yellow and the An interview on 06/ director of nursing were suppose to be he was not aware of cleaning schedule. A maintenance poli cleaning/repairs we	ulking was yellow and there coloration on the floor around proom had a strong, old urine ed that the caulk and flooring bathroom smelled like urine. (11/2015 at 10:54 a.m. the (DON) said the wheelchairs e on a cleaning schedule and of the lack of wheelchair for the lack of wheelchair	F 465	The wheelchair of resident number 1 wells and 16, 2015, the staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replace to the Maintenance Director were reviewed. Compliance will be monitored by the administrator through direct observation and review of the room maintenance a wheelchair cleaning checklists monthly three months. If noncompliance is not additional auditing and staff education be done. Compliance will be reviewed the September Quality Assessment ar Assurance Committee quarterly meeti	to airs. 4, eed. ns on und / for ed, will at d ng.
F 497 SS=F	REVIEW-12 HR/YF The facility must co of every nurse aide months, and must education based or reviews. The in-se sufficient to ensure nurse aides, but m per year; address a determined in nurs	SE AIDE PERFORM R INSERVICE omplete a performance review e at least once every 12 provide regular in-service in the outcome of these rvice training must be the continuing competence of ust be no less than 12 hours areas of weakness as e aides' performance reviews he special needs of residents	F 497	7	7/27/15

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		OMB NO. 0938-03 MULTIPLE CONSTRUCTION (X3) DATE SURVEY IILDING COMPLETED
		245349	B. WING	
	PROVIDER OR SUPPLIER	2+35+3	<u>D. m. d</u>	NG 06/17/2015 STREET ADDRESS, CITY, STATE, ZIP CODE
		ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI
F 497		nts, also address the care of	F 4	F 497
	by: Based on interview facility failed to ens received 12 hours of employees (EE-A, I EE-G, EE-H, EE-I, EE-N) who worked assistants and were employed greater th Findings include: Records provided in annual training in th included Tuberculo safety, Client Behar Alzheimer's Client. EE-A, EE-B, EE-C, EE-I, EE-J. EE-K, E	NT is not met as evidenced y and document review, the ure nursing assistants of training annually for 13 of 13 EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L, EE-M, in the capacity of nursing e reviewed who had been han 12 months by the facility.		 Stewartville Care Center completes a performance review of every nurse aide at least once every 12 months, and provides regular in-service education based on the outcome of these reviews. The in-service training ¿ (I) Is sufficient to ensure the continuing competence of nurse aides; (ii) Addresses areas of weakness as determined in nurse aides ¿ performance reviews as well as any special needs of residents; and (iii) Addresses the care of the cognitively impaired. The staff training related policies and
	were reviewed. EE EE-G, EE-H, EE-I, received a perform months, but the per identify areas for im training. EE-M, EE performance review leave during the tim according to the dir Medical Records (M provided total hours	A, EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L had ance review during the past 2 formance review did not provement or lack of 12-hour -N had not received a v, but had been on medical ne the reviews were completed		 The stan training related policies and procedures were reviewed and revised to ensure 12 hours of nursing assistant training per year including the training topics of abuse/neglect, fire safety, emergency procedures, tuberculosis, and caring for residents with dementia related behaviors. The Health Care Academy online program allows for tracking of training hours. All certified nursing assistants were required to complete 12 hours of training before July 27, 2015. The required training addressed caring for residents with

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU G			E SURVEY PLETED
		245349	B. WING _			06/1	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP		
STEWAF	TVILLE CARE CENTI	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF C CH CORRECTIVE ACTIO SS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 497	Continued From pa	ge 83	F 49				
		009 and had received 4.8 2014 and 8.12 hours of		cognitive impairments and dement related behaviors.		l dementia	
	hours of training in a in 2013. EE-C was hired in 2 of training in 2014 a 2013. In addition E dementia training . safety or emergence EE-D was hired in 2 hours of training in in 2013. EE-F was hired in 2 hours of training in in 2013. EE-G was hired in 2 hours of training in in 2013. In addition dementia training . emergency procedu EE-H was hired in 2 hours of training in 2013. EE-I was hired in 2 hours of training in 2013. EE-I was hired in 20 hours of training in 2013. EE-J was hired in 20 hours of training in 2013. EE-K was hired in 20 hours of training in 2014 a 2013. In addition EE	2010 and had received 2.2 2014 and 2.7 hours of training 2002 and had received 0 hours and 2.7 hours of training in E-C did not receive annual Tuberculosis (TB) training, fire y procedures training in 2014. 2011 and had received 01.5 2014 and 2.2 hours of training 2007 and had received 3.1 2014 and 3.2 hours of training EE-G did not receive annual TB training, fire safety or ares training in 2014. 2002 and had received 9.1 2014 and 0 hours of training in 012 and had received 2.3 2014 and 0 hours of training in 013 and had received 6.3 2014. 996 and had received 0 hours and 4.8 hours of training in E-K did not receive annual TB training, fire safety or and 4.8 hours of training in E-K did not receive annual TB training, fire safety or and 4.8 hours of training in E-K did not receive annual TB training, fire safety or ares training in 2014.		14, 15 a assistant regulate policies They w the requered employ The Bu resource complia nursing perform hours o to their necess schedu comple Complia	the mandatory mean and 16, 2015, the r ints were instructed by requirements a regarding continui- ere informed that p uired training is a c ment. siness Office Assiss the responsibilities w ance by auditing the assistants is require nance reviews and of continuing educa employment anniv ary, a specific time led for the nursing te the required train ance will be review aber Quality Assess nce Committee qua	aursing on the nd facility ing education. participating in condition of stant with human will monitor e dates of the ed annual the required 12 tion hours prior ersary date. If will be assistant to ning. ed at the sment and	

If continuation sheet Page 84 of 86

STATEMEN	OF DEFICIENCIES DF CORRECTION	KANNER STATE STREAM STREA	. ,	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245349	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETIC DATE
F 497	EE-M was hired in hours of training in training in 2013. EE-N was hired in of training in 2014. In addition EE-N di training . TB training procedures training Training records pr since February 201 EE-X had not comp programs entitled 0 for Alzheimer's Clife EE-R was hired as 3/25/15. EE-R's tra completion of dem EE-U was hired as 4/28/15. EE-U's tra completion of dem EE-X was hired as 5/12/15. EE-V'w tr completion of dem During an interview p.m. the director of assistant director of assistant director of responsible for star stated records wer During an interview ADON stated the a training programs t the Healthcare Aca stated the Tubercu dementia/behavior	1980 and had received 2.6 2014 and 4.32 hours of 2010 and had received 0 hours and 0 hours of training in 2013. d not receive annual dementia ag, fire safety or emergency g in 2014. rovided for employees hired 15 showed that EE-R, EE-U, pleted the two Health Academy Client Behaviors and Caring ent as follows: a nursing assistant on aining record did not document entia training. a nursing (DON) stated the of nursing (ADON) was ff development. DON also e kept per calendar year. a on 6/10/15 at 2:00 p.m. the administrator would assign the to be viewed by staff through ademy online program. ADON losis training program and training program were offered on and annual training	F 4	197		

If continuation sheet Page 85 of 86

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING		06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 497	6/10/15 at 2:10 p.m responsible to mon not do so. During an interview administrator stated the training program financial incentive t Undated policy enti Program was provid Healthcare Academ used and offered to work by the employ completion would b administration and to the assigned cou- be added on an as also noted the employ	n. and stated she was hitor staff training, but she did of on 6/15/15 at 1:30 p.m. the d he felt staff was completing ms since he offered and paid a to employees to do so. hitled Employee In-Service ded. The procedure indicated my eLearning services was b be completed at home or at yee. A designated dead line for be determined by department heads. In addition urses, additional courses could needed basis. The procedure bloyee and administration could rogress and generate reports	F 497			

Facility ID: 00429

If continuation sheet Page 86 of 86

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF		EB	TH STREET	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					07/17/15

STATE FORM

If continuation sheet 1 of 71

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of c	rrough June 17, 2015 epartment's staff, visited the I the following correction Please indicate in your orrection that you have lers, and identify the date wher tted.	n			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED - 06/17/2015	
		00429	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		/2010
STEWAR	TVILLE CARE CENT	FR	IRTH STREE [.] RTVILLE, MN	T NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
2 000	Continued From pa	age 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 285	MN Rule 4658.010 Orientation and In-	0 Subp. 2 Employee Service Education	2 285			7/27/15
	must provide in-set education must be continuing compete address areas ider assessment and a must address the se determined by the home must provide program in rehabili to promote ambula living; assist in acti of range of motion,	e education. A nursing home rvice education. The in-service sufficient to ensure the ence of employees, must ntified by the quality assurance committee, and special needs of residents as nursing home staff. A nursing e an in-service training tation for all nursing personnel tion; aid in activities of daily vities, self-help, maintenance , and proper chair and bed the prevention or reduction of				
	by: Based on interview facility failed to ens received 12 hours employees (EE-A, EE-G, EE-H, EE-I, EE-N) who worked assistants and wer	ent is not met as evidenced y and document review, the sure nursing assistants of training annually for 13 of 13 EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L, EE-M, in the capacity of nursing e reviewed who had been han 12 months by the facility.	3	See POC for F497		
	Findings include:					
	Records provided i					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED		
		00429	B. WING		06/	17/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
STEWAR	RTVILLE CARE CENT	FR	RTH STREET					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE		
2 285	Continued From pa	age 3	2 285					
	included Tuberculo	ne Healthcare Academy that sis, Fire Safety, Environmenta viors, and Caring for the						
	EE-I, EE-J. EE-K, E were reviewed. EE EE-G, EE-H, EE-I, received a perform months, but the per identify areas for in training. EE-M, EE performance review	EE-D, EE-F, EE-G, EE-H, EE-L, EE-M, EE-N records E-A, EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L had ance review during the past 2 rformance review did not provement or lack of 12-hour i-N had not received a w, but had been on medical ne the reviews were completed rector of nursing.						
	provided total hours	MR)-A on 6/16/15 at 12:45 p.m s of in-service training for 2013 3 employees reviewed as						
	hours of training in training in 2013. EE-B was hired in 2	2009 and had received 4.8 2014 and 8.12 hours of 2010 and had received 2.2 2014 and 2.7 hours of training						
	EE-C was hired in 2 of training in 2014 a 2013. In addition E dementia training . safety or emergend	2002 and had received 0 hours and 2.7 hours of training in E-C did not receive annual Tuberculosis (TB) training, fire cy procedures training in 2014 2011 and had received 01.5						
	hours of training in in 2013. EE-F was hired in 2	2014 and 2.2 hours of training 2007 and had received 3.1						
	in 2013.	2014 and 3.2 hours of training 2002 and had received 0						

STATE FORM

LEHX11

If continuation sheet 4 of 71

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET RTVILLE, MN &				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 285	Continued From pa	age 4	2 285				
	in 2013. In addition dementia training . emergency proced EE-H was hired in hours of training in 2013. EE-I was hired in 2 hours of training in 2013. EE-J was hired in 2 hours of training in EE-K was hired in 2 of training in 2014 2013. In addition E dementia training. emergency proced EE-L was hired in 2 hours of training in 2013. EE-M was hired in 2 hours of training in 2013. EE-M was hired in 2 hours of training in 2013. EE-N was hired in of training in 2014. In addition EE-N di training . TB training procedures training Training records pr since February 201 EE-X had not com	1996 and had received 0 hours and 4.8 hours of training in E-K did not receive annual TB training, fire safety or ures training in 2014. 2022 and had received 2.3 2014 and 0 hours of training in 1980 and had received 2.6 2014 and 4.32 hours of 2010 and had received 0 hours and 0 hours of training in 2013 d not receive annual dementia g, fire safety or emergency g in 2014. Tovided for employees hired 15 showed that EE-R, EE-U, oleted the two Health Academy Client Behaviors and Caring	n n 5				
	3/25/15. EE-R's tra completion of dem EE-U was hired as	a nursing assistant on aining record did not document entia training. a nursing assistant on aining record did not document					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET I RTVILLE, MN 5			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 285	Continued From pa	age 5	2 285			
E 5 c p a r	completion of dementia training. EE-X was hired as a nursing assistant on 5/12/15. EE-X's training record did not document completion of dementia training.					
	p.m. the director of assistant director of responsible for sta	v on entrance on 6/8/15 at 3:00 f nursing (DON) stated the of nursing (ADON) was ff development. DON also re kept per calendar year.				
	ADON stated the a training programs to the Healthcare Aca stated the Tubercu dementia/behavior as part of orientation program. The ADC 6/10/15 at 2:10 p.m	v on 6/10/15 at 2:00 p.m. the administrator would assign the to be viewed by staff through ademy online program. ADON losis training program were offered on and annual training DN was interviewed again on n. and stated she was nitor staff training, but she did				
	administrator state the training program	v on 6/15/15 at 1:30 p.m. the d he felt staff was completing ms since he offered and paid a to employees to do so.				
	Program was provi Healthcare Acader used and offered to work by the employ completion would be administration and to the assigned co- be added on an as also noted the emp	department heads. In addition urses, additional courses could needed basis. The procedure ployee and administration could rogress and generate reports				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 285	Continued From pa	ige 6	2 285				
	administrator could regards to staff hav the needs of all res dealing with difficult dementia managen	THOD OF CORRECTION: The monitor for compliance in ring ongoing education to meet idents especially in regards to t resident behavior and nent. R CORRECTION: Twenty-one					
	(21) days.	Toormeonon. Twenty one					
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			7/27/15	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related of segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	L				
	related disorders; (2) assistance with (3) problem solving and (4) communication	of Alzheimer's disease and activities of daily living; with challenging behaviors; skills.					
	written or electronic training program, th trained, the frequer topics covered.	I provide to consumers in c form a description of the ne categories of employees ney of training, and the basic I document compliance with					

STATE FORM

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	EB	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 7	2 302			
	this section.					
	This MN Requireme	ent is not met as evidenced				
		and document review, the ure that 10 of 10 employees		See POC for F497		
	(EE-0, EE-P, EE-R,	EE-S, EE-T, EE-U, EE-W,				
	dementia training w	reviewed for having received vere found to have not				
	received timely den	nentia training.				
	Findings include:					
	Program was provid Healthcare Academ used and offered to work by the employ In-service TB [tuber also "Client Behavid	tled Employee In-Service ded. The procedure indicated by eLearning services was be completed at home or at ee. The procedure read, "J. rculosis] it's a Cough Away" or" and "Caring for Alzheimer's mpleted before starting work."				
	(CMS671 and CMS residents currently	nation provided the facility 672) noted the facility had 68 in the facility and that included ementia and 20 residents that wiors.				
	The training records following new hires	s were reviewed for the				
	Records provided in courses had been of EE-P hired 3/17/15 Records provided in courses had been of EE-R hired 3/25/15	as a dietary staff member. ndicated neither of the two				
/innesota D	epartment of Health					

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
	PROVIDER OR SUPPLIER		DBESS CITY S	TATE, ZIP CODE	00/	06/17/2015	
		120 FOUR		NORTHEAST			
SIEWAI	RTVILLE CARE CENTI	STEWAR	TVILLE, MN (55976		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 302	Continued From pa	ge 8	2 302				
	courses had been of EE-S hired 3/19/15 Records provided in courses had been of EE-T hired 4/8/15 a Records provided in courses had been of EE-U hired 4/28/15 Records provided in courses had been of EE-W hired 5/5/15 employee. Records the two courses had EE-X hired 5/12/15 Records provided in courses had been of EE-Y hired 6/3/15 a was observed during floor as a new empl Records provided in courses had been of EE-Z was hired 1/12 nurse. Records pro- two courses had been of EE-Z was hired 1/12 nurse. Record	as a dietary staff member. Indicated neither of the two completed. Is a dietary staff member. Indicated neither of the two completed. as a nursing assistant. Indicated neither of the two completed. as a medical record provided indicated neither of d been completed. as a nursing assistant. Indicated neither of the two completed. Is a registered nurse. EE-Y Ig the survey working on the loyee with another nurse. Indicated neither of the two completed. 2/15 as a licensed practical vided indicated neither of the two completed. 2/15 at 2:10 p.m. ADON stated e to monitor staff training. Vas not aware that the ten new been trained in caring for the					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	age 9	2 302			
	The director of nurs an orientation prog that would ensure r education and inse for cognitively impa	THOD OF CORRECTION: sing or designee could develop ram and monitoring system new employees receive rvice training related to caring aired residents. R CORRECTION: Twenty-one				
2 560		5 Subp. 2 Comprehensive ents	2 560			7/17/15
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan tota Statutes, section 626.557, agraph (b).				
	by: Based on record refailed to develop a mood, behavior and of 5 residents (R45 medications. Findings include: R45 was admitted to the facility admist that included but we disorder. R45's significant ch (MDS) dated 3/12/	ent is not met as evidenced eview and interview, the facility comprehensive care plan for d psychotropic drug use for 1 b) who received psychotropic to the facility 6/12/14 according esion record with diagnoses as not limited to bipolar nange Minimum Data Set 15 indicated moderate PHQ-9 (resident mood		See POC for F280		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 560	Continued From pa	age 10	2 560			
	bipolar disorder, an care rejection, and when compared to addition, the MDS i antipsychotic and a Care Area Assessm based off of the ME that required a plan as a result of the M mood state, behavin psychotropic drug u R45's physician ord 6/10/15 included L6 medication) 20 mill Wellbutrin XL (antion mg per day, Depak used as a mood stat day, and Zyprexa (a ta bedtime. R45's care plan dic included individuali the triggered care a and psychotropic d was identified; the d in regards to care a depression and ass During an interview MDS coordinator lia (LPN)-G verified th CAA's triggered by state, behavioral sy drug use should ha plan. The facility policy M Assessment Protoc dated does not refuse SUGGESTED MET The Director of Nut	9, identified diagnosis of ad indicated behavior status, wondering had worsened previous assessment. In indicated R45 received antidepressant medications. nent (CAA's) were triggered DS assessment information n of care. The CAA's triggered IDS assessment included: ioral symptoms, and use. ders provided by the facility on exapro (antidepressant igrams (mg) once per day, depressant medication) 300 cene (anti-seizure medication abilizer) 250 mg two times per antipsychotic medication) 5 mg d not include a plan of care that zed goals and interventions for areas for behavioral symptoms rug use. Although depression care plan lacked interventions and services associated with sociated mood state concerns. <i>v</i> on 6/10/15 at 1:00 p.m., the censed practical nurse e care plan did not reflect the the MDS. LPN-G stated mood ymptoms, and psychotropic ave been included in the care Minimum Data Set/Resident col/Care Planning that was not ect current standards. THOD OF CORRECTION: rsing or designee could ind/or revise policies and				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/17/2015	
		00429	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	TH STREET	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 11	2 560			
	ensure appropriate Director of Nursing appropriate staff or and could develop ongoing compliance	re care plans are developed to care of residents. The or designee could educate all the policies and procedures, monitoring systems to ensure e. R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			7/17/15
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an im that includes the attending ored nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal a representative at least a seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to revised the plan of dietician's recommendations R65) reviewed.		See POC for F325		
	Findings include:					
	supplement was give	e supplement however, the ven to the resident but the was not documented and the				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00429	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	to determine if ther in stabilizing weight (RD)-B's progress is staff to monitor inta monitoring food and indicated on the ca R65's care plan dat able to feed self aft needs observing if needed." The lister provide setup for re apply condiments, of An interview on 06/ certified dietary ma wanders up and do weight this month, of The nurses gave he times a day. No or she eats at a meal track now. An interview on 06/ registered dietician her meals well and times a day. R65 ei walking so much. I loss of 9.2% for the her weight loss is 1 "She is on the risk months now." RD-	of meals was not documented e was an effective intervention t loss. The registered dietician note dated 5/7/15, indicated ke; although, The need for d supplement intake was not				
	An interview on 06/ registered nurse (F	11/2015, at 9:09 a.m. with N)-G who said R65 takes her three times a day but said no uch is consumed.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	FB	IRTH STREET RTVILLE, MN :				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 13	2 570				
	"Nursing service and "Need for an ir monitored by nursi SUGGESTED ME The Director of Nur develop, review, ar procedures to ensu ensure appropriate Director of Nursing appropriate staff or	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure care plans are developed to a care of residents. The or designee could educate all n the policies and procedures, monitoring systems to ensure	0				
		R CORRECTION: Twenty-one					
2 830	Proper Nursing Ca Subpart 1. Care in receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	a general. A resident must re and treatment, personal and I supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be our possible unless there is a the attending physician that the ain in bed or the resident	d t			7/16/15	
	This MN Requirem by:	ent is not met as evidenced					

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREE [®] TVILLE, MN	T NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO IUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	review, the facility	tion, interview and record failed to reassess pain after a n for 2 of 2 residents (R11 & ain.		See POC for F309		
	Findings include:					
	and stated she had shoulders. R11 sta medication for it ar pain in the area tha (scale 0 no pain ar she used Ultram (p she had "out-grown needed to have bo repaired, but did no 6/11/15 at 6:15 p.m her chair and eatin shoulder pain was nothing was being		I			
	diagnoses listed or included: chronic p Physician orders o Ultram twice a day scheduled Tylenol	to the facility in 2006 and had in the physician orders that pain and osteoarthrosis. f 6/11/15 included: scheduled and as needed (PRN), extra strength twice a day, narcotic medication) three				
	otherwise continue to her arthritis in he failed all conservat	vsician note read, "Patient s to have symptoms in regards er shoulders. Patient also has ive therapies for that." 'degenerative joint disease - mptomatic."	3			
		num Data Set (MDS) indicated prief interview of mental status)				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	FB	IRTH STREET RTVILLE, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	R11 had rated her	ve impairment and indicated pain at 6 out of 10 but that an in was not necessary.				
	7/9/14 indicated the at 10 in the should received scheduled medications, had li range of motion. T	essment (CAA) completed e resident would rate her pain ers and arms, that she d and as needed (PRN) pain mited bilateral functional The CAA read, "She may be at sx [symptoms] of pain limiting or falls and injury."				
	dated 3/23/15 note					
	licensed practical r usually had pain ar wanted her to have The facility would a LPN-J stated she t the "gas" (air in box	v on 6/11/15 at 6:24 p.m. hurse (LPN)-J stated R11 hd that the physician only e pain medications for control. also provide warm packs. hought the pain was related to wels) in the abdomen and that se a rectal tube and anti-gas				
	regards to a pain a stated that she was assessments and a in the hard copy ch	v on 6/11/15 at 11:30 a.m. in issessment for R11, RN-F s just starting to do pain any pain assessment would be part. However, none was ad when requested.				
	stated that her legs her bottom was so	d on 6/8/15 at 6:29 p.m. and s ached. R2 also stated that re because of cancer and use anical lift. R2 stated her pain				

STATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	level was up to 7 of not have any.	ut of 10 scale, but currently did				
		ce on 4/7/15 documentation I she was having more pain				
	ankle pain and swe	ntation of 4/20/15 noted right elling for R2. The nursing 5/20/15 through 6/11/15 did not lent having pain.				
	BIMS of 14 or no consection was left une	ated 12/23/14 indicated a ognitive impairment, the pain done. The quarterly MDS ated a pain intensity of 7 on a				
		ed 4/6/15 indicate the resident ut and generalized pain usually ers.	,			
	coordinator, stated	11:30 a.m. RN-F, the MDS that she was just starting to do and had not done any for R2				
	Pain Evaluation Propain was to be reas condition indicates On 06/11/2015 at 1 nursing stated he wassessments be co	2:03 p.m. the director of				
	director of nursing give direct care the	THOD OF CORRECTION: The could in-service all staff who need to assess and provide nts and cares related to				

Minnesc	ta Department of He	ealth			FORM APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00429	B. WING		06/17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEWAF		FR	RTH STREET TVILLE, MN	FNORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 830	Continued From pa	ige 17	2 830		
	current health need compliance.	ls. Also to monitor for staff			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 965	MN Rule 4658.0600 -Nutritional Status	0 Subp. 2 Dietary Service	2 965		7/17/15
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food			
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to comprehensively al status for 1 of 3 residents nutritional status.		See POC for F325	
	Findings include:				
	180 days however,	nt weight loss over the past interventions put in place l/assessed if appropriate to eight.			
	supplement was giv actual amount cons and the amount con documented to dete	e supplement however, the ven to the resident but the sumed was not documented nsumed of meals was not ermine if there was an on in stabilizing weight loss.			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
STEWAF		-B	RTH STREET I TVILLE, MN 5			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
TAG	HEGGERIONT ON E		TAG	DEFICIENC		57.12
2 965	Continued From pa	ge 18	2 965			
	 R65's most recent weight from dietary resident progress note dated 6/10/2015, was 114 pounds reflected weight loss of four pounds (3.4 percent) past 30 days, six pounds (5 percent) past 90 days and 16 pounds (12.3 percent) past 180 days. Weight loss is significant past 180 days. Dietary progress notes authored by the registered dietician (RD)-B dated 5/7/15, indicated resident's current weight is 118 pounds. This reflects weight loss of 9.2 percent in 6 months. Recommended house supplement be increased to four ounces three times a day to prevent further weight loss was initiated and staff to monitor intake. R65 was admitted with diagnoses that included dementia and CVA (cerebral vascular accident). 					
	4/28/15, identified F eating. the MDS al problems with coug complaints of difficu significant change I required supervisio	n Data Set (MDS) dated R65 required supervision for so indicated R65 had no hing/choking during meals or ult chewing or swallowing. The MDS dated 1/28/15, R65 n, oversight, encouragement eal time. R65's weight was time.				
	6/9/15, with the only meals consumed w which indicated an supplement to 4 oz loss." On 5/22/15, around 6 hours war offered food, fluid No other mention o	otes reviewed from 3/17/15, to y time when the amount of ras mentioned was on 5/12/15, "increase in house with each meal for weight the progress note read, "Up ndering up and down halls. Is and activity as appropriate." f food consumed was ny provided when requested.				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STEWAI	RTVILLE CARE CENTI	FR	RTH STREET I TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Medication flow she until 6/10/15, indica house supplement consumed. The me until 5/31/15, indica supplement with the 6/1/15. Monthly we sheet during this pe A dietary nutritional indicated no concernutritional assessme time. Computer generate received from certif weight on 1/5/15, 12 lbs; 3/1/15, 120.4 II 118.4 lbs; 6/1/15, 12 Observations on 6/ 75% of her meal. ate 50% of meal. An interview on 06/ CDM who said R65 hallway. She lost weighs 114 lbs. Th supplement three ti keeps track of how they will start keepin An interview on 06/ said R65 consumes supplement three ti energy by walking s had a weight loss on As of today her wei	eets reviewed from 3/1/15, te R65 given four ounces of but no monitoring of amount edication flow sheet for 3/1/15, te once a day house ree times a day started on eights also listed on medication eriod. assessment dated 1/28/15, rns at that time and no further ents were provided since that ed weight variance report ied dietary manager (CDM), 27.8 pounds (lbs); 2/2/15, 124 bs; 4/1/15, 120 lbs; 5/1/15, 14 lbs. 10/15, at 12:06 p.m. R65 ate On 6/11/15, at 12:03 p.m. R65 10/2015 at 12:32 a.m. with 6 wanders up and down the reight this month, currently she e nurses give her a house mes a day. However, no one much she eats at a meal but		DEFIGIENC		

	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEWAF	RTVILLE CARE CENT	FR	RTH STREET RTVILLE, MN &				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 20	2 965				
	at what the nurses nutritional supplem	are signing out for her ent.					
	registered nurse (F house supplement does not measures anyone record how An interview with R	(11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said s how much is given nor does y much is consumed by R65.					
	much supplement t	I they have not assessed how the resident consumes. They not assess effectiveness of the s not monitored.					
	director of nurses (expectation is the c of the meal R65 ea monitor how much	(11/2015, at 9:55 a.m. with DON) who stated my dietary staff monitor how much ats and nursing needs to supplement R65 consumes of ien they give it to her.					
	feed self after setu observing if she is The listed approach for reach meal-ope	ted 2/2/15, read, "Is able to p is provided and needs eating and assist as needed." h is "One staff to provide setup en containers, apply ods and butter breads."					
	preventing ongoing residents in the fac they exhibit an une	ntitled monitoring and y weight loss read, "All ility will be weighed monthly. If xpected continual weight loss y will be addressed as a risk ns will begin."	f				
	nutritional risk read following conditions	00, entitled residents at l, "Residents with any of the s should be considered at v body weight and increased					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	·		
		00429	B. WING		- 06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FB	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 21	2 965			
	caloric and/or nutrie condition."	ent needs related to medical				
	"Nursing service I	00, entitled supplements read, record intake of supplement" take of supplement will be ng personnel."				
	registered dietician responsible for resi need to monitor and by the dietician and	HOD OF CORRECTION: The could in-service employees dent nutritional needs on the d follow interventions advised the doctor to maintain weight oss. Then to monitor staff for				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			7/17/15
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review the facility fa equipment was disi bactericide sanitize directions for a gluo residents (R29, R1 ⁻¹ observed. In addition	ent is not met as evidenced on, interview and document alled to ensure glucometer nfected according to the r wipe manufacturers cometer used for 3 of 4 1 & R24) glucose tests on the facility failed to ensure d incontinent products and		See POC for F441		

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 22	21375				
	soiled gloves to pre which could affect s	event the spread of infection several residents.					
	Findings include:						
	9:22 a.m. registere doing glucose test. monitoring, RN-B v seconds with the S stated, "I guess we the manufacturers	cose testing done on 6/10/15 a d nurse (RN)-B was observed After completion of the viped the glucometer for 20 uper Sani-Cloth wipe. RN-B wipe it a while." However, directions say to allow the fected to remain wet for a" full	t				
	6/10/15 at 6:20 p.m (LPN)-A perform gl glucometer was ren cart and taken dire stated the facility a maintained the mon to the medication of of the glucose testi Sani-Cloth wipe to remained in contact one minute and the top of the medication did not know how le contact with the medication directions say to all	to have glucose test done on h. licensed practical nurse ucose monitoring for R11. The moved from the medication ctly into R11's room. LPN-A nd not the resident owned and nitors. When LPN-A returned eart following the performance ng, She used the PDI Super clean the meter. The wipe et with the meter for less than a damp monitor was placed on on cart. LPN-A stated that she ong to keep the disinfectant in peter. Again the manufacturers low the surface to be in wet for a" full 2 minutes."					
	at 6:30 p.m. LPN-E glucometer after us Sani Cloth wipe an the monitor for less finished LPN-B pla	leted glucose test on 6/10/15 8 was observed to clean the se. LPN-B used the PDI Super d left the wipe in contact with s than one minute. When ced the damp monitor on top k. LPN-B stated the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 23	21375			
	monitor for 10 to 15 manufacturers dire	eeded to be in contact with the 5 second. Again the octions say to allow the surface o remain wet for a" full 2				
	Meters Clean and I meter, wipe down t registered and app	y policy entitled Blood Glucose Disinfect read, "To disinfect the he meter with an EPA roved premoistened the product label instructions to .")			
	6/10/15 at 9:57 a.m	sing was interviewed on n. and stated staff need to s on the PDI package to neter.				
	PADS AND GLOVE SPREAD OF INFE During an observat soiled incontinent p	tion on 6/8/15, at 6:18 p.m. a bad and gloves were laying on between resident rooms				
	During an interview licensed practical r soiled incontinent stated should have LPN-B donned glov pad in the garbage	v on 6/8/15, at 6:22 p.m. hurse (LPN)-B verified the product on the floor. LPN-B not been left on the floor, ves and placed the incontinent bag and removed from room.				
	An undated facility Morning Care) read and dispose of disp linen appropriately.	policy AM Cares (Early d, "Leave bedside area clean, posable equipment and soiled " An undated facility policy e Care) read, Leave room				
	An undated facility	policy Incontinence Care ed, "Discard disposable items ag and secure."				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00429	B. WING			06/17/2015
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE	00/	17/2015
	RTVILLE CARE CENT	FR 120 FOU	RTH STREET I RTVILLE, MN 5	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 24	21375			
	administrator, direct consulting pharmace policies and proceed glucometer meters educated as necess correct cleaning pro- The administrator a could audit residen ensure a compliance	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for infection control of . Housekeeping staff could be sary to the importance of ocedures of waste materials. and housekeeping director t areas on a regular basis to ce. R CORRECTION: Twenty-one				
21426	Prevention And Co (a) A nursing home maintain a comprel infection control pro current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). cinclude a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.	21426			7/27/15

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	-R	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 25	21426			
	by: Based on interview facility failed to ensu annual Tuberculos nursing department EE-DD, EE-FF, EE	ent is not met as evidenced and document review, the ure all employees received is (TB) training for 6 of 50 employees (EE-AA, EE-CC, -HH, EE-LL). In addition the in annual TB training.		See POC for F497		
	Findings include:					
	Program was provid Healthcare Academ used and offered to work by the employ In-service TB [tuber also "Client Behavid Client" must be con	tled Employee In-Service ded. The procedure indicated by eLearning services was be completed at home or at ee. The procedure read, "J. rculosis] it's a Cough Away" or" and "Caring for Alzheimer's npleted before starting work." nclude the staff were to be annual training for				
		IR)-A was interviewed on n. and had provided hours of related to TB for all				
		ere provided for 50 nursing staff records had not received ollows:				
Ainnesota D	6/18/12					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING	B. WING		17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FB	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 26	21426			
	(LPN) on 4/7/98	s a licensed practical nurse an NA on 5/15/96				
	2014 and 2015. The included a hand our nine employees has Cough Away" training policy/procedure as EE-GG was hired as EE-JJ was hired as EE-MM was hired as EE-NN was hired as EE-NN was hired as EE-OO was hired as EE-PP was hired as	as a NA on 6/17/14 s an RN on 9/9/14 s an NA on 11/25/14 as an NA on 11/12/14 as an NA on 3/25/15 as an NA on 4/28/15 s an NA on 8/11/14 as an NA on 5/12/15	9			
	interviewed on 6/10 she was responsible	tor of nursing (ADON) was)/15 at 2:10 p.m. ADON stated le to monitor staff training and nine staff TB training.				
	medical director or in-service staff resp most current MDH	THOD OF CORRECTION: The director of nursing could consible for TB to follow the guidance on TB program for to monitor for compliance.	;			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21495	MN Rule 4658.100 Providing Social Se	5 Subp. 5 Social Services; ervices	21495			7/27/15
		g social services. Social rovided on the basis of				

STATEMEN	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00429	B. WING		06/	17/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE				
STEWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE		
21495	Continued From pa	age 27	21495					
	according to the co assessment and co	vice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.						
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26.			See POC for F247 and F250				
	according to the fac R26's quarterly Mir 4/15/15 indicated n was independent w During an interview answer to the ques concerns or proble other resident," R2 to say that she had quarterly MDS date impairment) who liv shared the same b to say that her roor moderate cognitive quarterly MDS date yelled and cursed a over the past mont door locked so she residents room to u	to the facility on 4/29/14 cility admission record. himum Data Set (MDS) dated o cognitive impairment and vith activities of daily living. on 6/9/15, at 8:26 a.m. in an tion "Have there been any ms with a roommate or any 6 stated, "Yes.!" R26 went on problems with R1 (R1's ed 4/8/15 shows no cognitive yed in the adjacent room and athroom as R26. R26 went on nmate (R68 who had impairment according to the ed 5/6/15). R26 stated R1 had at her on multiple occasions hs and kept R26's bathroom had to go into the other unlock it to use on several en said her roommate (R68)						

STATEMEI	Dta Department of He NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	L	DRESS, CITY, ST	ATE. ZIP CODE		11/2010
		120 FOU	RTH STREET I			
SIEWA	RTVILLE CARE CENT	ER STEWAR	TVILLE, MN 5	5976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21495	Continued From pa	age 28	21495			
	watch television, w when and how to g seemed to want m for her things. In re does that make you you what to do?" F bossy, I feel like I'm her, she's always te reported it to the so concerns, I'm not s is still hereI'm not my concerns. They less just got used te anything more." R2 very loud at night a stated she did not y had been treated (i R68) and was not e because nothing ha help from the facilit not to deal with it, f with it. During a follow up p.m. R26 indicated well with problems roommate (R68) ar me now It still hun frustrated, I'm not a to the question, "He stated, "When [R68 know what I did, bu dealt with the neigh a bedside commod confrontation with. preferred to use the commode. R26 sta bit without one of th am doing." R26 sta	to go to bed, when she could here to put her walker, and et dressed. R26 stated R68 pre space in the shared room sponse to the question, "How a feel to have someone telling R26 stated, "She is kinda n walking on eggshells around elling me what to do. I've bocial worker about the ure if the same social worker t aware if she followed up with come and go fast. I more or o it, so I don't even say to further stated R68 snored nd kept her awake often. R26 want to be treated the way she n reference to both R1 and expecting anything to change ad changed despite asking for y. R26 stated it would be nice nowever had learned to deal interview on 6/10/15, at. 1:30 she had not been able to cope with neighbor (R1) and nd said, "I try not to let it bother rts my feelings, and I'm a child you know." In response bw do you deal with it?" R26 B] starts in, I just say "I don't it I'm sorry." R26 stated she abor bathroom issue by having le at night to avoid R26 stated she would e bathroom vs. the bed side ted, "I can't even move a little nem questioning me on what I ated she had asked for a room inths ago, stated the social				

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00400	B WING		00/17/0015		
				06/	06/17/2015	
ROVIDER OR SUPPLIER						
VILLE CARE CENTI	FB					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE	
Continued From pa	ge 29	21495				
worker had not eve stated, " I am tired nothing changes, su learned to deal with R26's care plan pro- read, "Has occasion her roommate and common bathroom support with is as n included interventio to resident and enc concerns and feelin explanation of diffic resolve the concern Social service prog "[R26] came to soc on 12/5/14 seeking other residents. She particularly cruel on that hurt was comp whom she has prev relationship with, al has been also mak past monthshe h often but that appea for her. She is adju- avoid confrontation place in the hallway with the supervisors pros and cons of a advised to speak w thoughts on the inter place." The progress services would con- support and indicate social worker would R1's progress notes of follow-up perform R26 shared with so	r come in to talk with her. R26 of reporting the concerns and o what's the point? I've just it." wided by the facility on 6/11/15 nal difficulties in dealing with others that she share a with but seeks out staff eeded. Care plan also on of "provide on-going support ourage resident to share her ng." The care plan lacked rulties and interventions to ns. ress note dated 12/5/14 read, ial work office late in the day support due to conflicts with e describes one resident being an ongoing basis and said ounded when her roommate, <i>r</i> iously shared a good igned with the other party and ing hurtful remarks over the as tried to speak back more ars to be making things worse sting her bathroom routines to The comments also take <i>rs</i> and dining room. I spoke is about the situation and the room change and was ith roommate to ascertain her eractions reported to be taken as note further indicated social tinue to offer emotional ed if problem persisted the d attempt mediation. s were reviewed, no evidence ned related to the concerns of cial worker on 12/5/14. R1's					
	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER VILLE CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa worker had not eve stated, " I am tired nothing changes, si learned to deal with R26's care plan pro- read, "Has occasion her roommate and common bathroom support with is as n included intervention to resident and ence concerns and feelir explanation of diffic resolve the concern Social service prog "[R26] came to soc on 12/5/14 seeking other residents. Shi particularly cruel or that hurt was comp whom she has prev relationship with, al has been also mak post monthshe h often but that appea for her. She is adju- avoid confrontation place in the hallway with the supervisors pros and cons of a advised to speak w thoughts on the inter place." The progress services would con support and indicat social worker would R1's progress note: of follow-up perform R26 shared with so	OF CORRECTION IDENTIFICATION NUMBER: 00429 ROVIDER OR SUPPLIER STREET AL TVILLE CARE CENTER 120 FOUL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 worker had not ever come in to talk with her. R26 stated, " I am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it." R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns. Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with	OF DEFICIENCIES PF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: O0429 (X2) MULTIPLE A. BUILDING: B. WING	OP DEFICIENCIES (X1) PROVIDERSUPPLER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: O0429 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERS PLAN OF IEACH CORRECTIVE ACI CROSS REFERENCED DEFICIENC Continued From page 29 21495 worker had not ever come in to talk with her. R26 stated, "1 am tired of reporting the concerns and nothing changes, so what's the point? I've just learned to deal with it." R26's care plan provided by the facility on 6/11/15 read, "Has occasional difficulties in dealing with her roommate and others that she share a common bathroom with but seeks out staff support with is as needed. Care plan also included intervention of "provide on-going support to resident and encourage resident to share her concerns and feeling." The care plan lacked explanation of difficulties and interventions to resolve the concerns. Social service progress note dated 12/5/14 read, "[R26] came to social work office late in the day on 12/5/14 seeking support due to conflicts with other residents. She describes one resident being particularly cruel on an ongoing basis and said that hurt was compounded when her roommate, whom she has previously shared a good relationship with, aligned with the other party and has been also making hurtuf remarks over the past monthshe has tried to speak back more often but that appears to be making things worse for her. She is adjusting her bathroom routines to avoid confrontation The comments also take place. The	OPERFICIENCIES FCORRECTION (X) PROVIDERIS/PRUERCULA IDENTIFICATION NUMBER: 00429 (X) MULTULE CONSTRUCTION A BUILDING; 	

STATE FORM

STATEME	Dia Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
		120 FOU	RTH STREET N				
SIEWA	RTVILLE CARE CENT	ER STEWAR	TVILLE, MN 5	5976			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21495	Continued From pa	ge 30	21495				
	argumentative disp residents. She has other" The care p confrontational with multiple room chan reflect the issue wit R1. R68's progress not of follow-up perform R26. R68's care pla concerns, intervent roommate. R26's progress not monitoring had bee voiced concerns at further mention of t the resident brough again in her care co Care conference pr read, "We provided about her interaction next door neighbor, issues. She reports same but she had g She tends to accom spoken up." No follow-up was e medical record as a concerns and issue conference. During an interview licensed social work staff reported to he to the residents and going on" however, aware of the conce documented in the the facility had turne	osition at times with other verbal behaviors toward lan also indicated she is residents and has had ges. The care plan did not h the shared bathroom with es were reviewed, no evidence ned related to the concerns of an did not reflect or identify any ions, or problems with es did not reflect follow-up or on performed as a result of the 12/5/15 meeting and no he issues until 4/29/15 when it the same concerns forward					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING	B. WING		17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
		120 EOU	RTH STREET			
SIEWAR	RTVILLE CARE CENT	STEWAR	TVILLE, MN 5	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	age 31	21495			
	During an interview director of nursing not been filled. DON have been filled out with roommate (R6 he had not been av roommate despite the medical record, should have been f his expectation wor a situation for a pos worker involvement During an interview family member (F)- roommate and neig roommate had alwa telling [R26] what to TV off, when to go things I hear it. [F thing, sarcastic thin doesn't want to lister really frustrated, ev Every time I call sh her roommate. I ha [R26's] mood but I stated had not been ongoing issues corn neighbor. F-A expla R26, but had been handling the proble think [R26] is happy think she is happy, were not around sh of life. [R26] was ne know if she was up deal with it and dea a while before she	v on 6/10/15, at 2:08 p.m., A indicated awareness of ghbor problems. Stated the ays been complaining and o do, "[R68] tells her to turn the to bed, and where to put R68] is always saying smart ags to [R26]. [R26] says she en to her. She [R26] seems reryday there is something. e expresses frustration with aven't noticed a big change is do know she is frustrated." F-A n notified by the facility of the accerning the roommate or the ained had offered assistance to told by R26 she had been ems. To the question, "Do you y?" F-A stated, "No, I don't I would think if those people ne would have a better quality ever a person who let people set about something. She will al with it until it explodes, takes reports anything. She doesn't es, she wants to just do her				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
		120 EOU	RTH STREET				
SIEWA	RTVILLE CARE CENT	ER STEWAR	TVILLE, MN 5	55976			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21495	Continued From pa	ige 32	21495				
	nursing assistant (N judgmental of peop R26's bathroom con the door so R26 ca NA-K further stated the roommate, "[R6 line [which divides r goand they have [R26] was shutting explained R26 was concerns, "she wou bad." NA-K explain resident concerns, social worker. During an interview licensed practical n not been aware of t roommate despite t the medical record. knew about the who sure everybody kne commode had been compromise to the During an interview NA-E stated "[R1] t aggressiveshe ter a little more vulnera [R26] about the bat about letting people wants things a certa sideR26 will just s seen her get upset of person that holds tries to get along wi keeps to herself." I where R68 had atte down and had to be During an interview	nds to pick on people that are ableshe really goes after throomand is very vocal e know." NA-E stated, "[R68] ain way even if it's on [R26's] shrug it off and ignore it. I have and frustrated. She's the type s things in. She is the type that ith everyone, she is quiet and NA-E explained an example, empted to take R26's calendar					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00429	B. WING		06/-	7/2015
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21495	Continued From pa	age 33	21495			
	of the problems with bathroom with R26 An undated policy of grievances/complation and/or complaints writing." "The adm responsibility of gri investigation to Social a grievance and/or investigate the alle report of such findi (5) working days of and/or complaint. An undated facility Clinical Record rea Records of each rea about personal and related to the resid	entitled filing ints indicated "Grievances may be submitted orally or in inistrator has delegated the evance and/or complaint cial Services." Upon receipt of complaint, Social Services will gation and submit a written ng to the administrator within f receiving the grievance policy entitled Content Of The ad, "Records of Social Service. esident's pertinent social data d family problems medically ent's illness and care and of et these needs, will be entered				
	The director of nur ensure arrangeme residents with med services related to to resident confron	THOD OF CORRECTION: sing and social worker could nts were made to provide lically necessary social roommate issues and resident tations in the facility. R CORRECTION: Twenty One				
21610	and Preparation Ar Subpart 1. Storage must store all drug	0 Subp. 1 Medicine Cabinet ea;Storage e of drugs. A nursing home s in locked compartments erature controls, and permit	21610			7/17/15
	only authorized nui					1

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00429	B. WING		06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	-R	RTH STREET IVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 34	21610			
	access to the keys.					
		ent is not met as evidenced				
	facility failed to ensi- of used Fentanyl (to medication) patche accepted principles for 2 of 2 residents prescribed Fentany that were outdated accidental use and open date to determ outdated this had th residents including R10, & R71) who u prescription medicat	and document review, the ure safe and secure disposal opical narcotic analgesic s according to currently to prevent potential diversion (R7 & R55)reviewed with I patches. Also medications were not removed to prevent medications opened lacked nine when it would be ne potential to affect several (R29, R4, R65, R42, R46, tilized stock medications and tions.		See POC for F431		
	diagnosis including sensation with pain	lumbago and abnormal in the left leg.				
	order for Fentanyl p be applied transder hours, with special and change patch o pain. **When remo and flush down toile R7's Fentanyl patch and stored in the W	Ars dated 5/14/15, included an patch 25 micrograms (mcg) to mal (to the skin) every 72 instructions, "Apply 1 patch q [every] 72 h [hours] for back ving old patch, wrap in tissue et or put in sharps container.**" hes were administered from 'est medication cart.				
	diagnosis including R55's physician orc					
Minnesota D	epartment of Health	aton ou moy to be applied				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	-	21610			
	instruction, "When tissue and flush do container.**" R55's	72 hours, with special removing old patch, wrap in wn toilet or put in sharps Fentanyl patches were and stored in the North				
	During an interview on 6/8/15, at 7:15 p.m., trained medical assistant (TMA)-A indicated the policy when removing and disposing of Fentanyl patches, was for two staff to witness the destruction by putting them in the sharps container attached to the medication cart, and for both to initial on the Medication Administration Record (MAR).					
	medication adminis medication cart, the container attached unlocked and could the content in the s container was easi compartment by sli from the cart. The several pieces of o	tion on 6/10/15, at 8:40 a.m., of stration from the West e locking door on the sharps to the cart was observed to be d easily be opened, exposing sharps container. The sharps ly removed from the iding it forward and removing door to the compartment had ld tape on the front and ape on the right side of the				
	at 8:50 a.m., the Ea container compartr unlocked and could the sharps containe easily removed from forward. Licensed	medication storage on 6/10/15, ast medication cart sharps nent door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding it practical nurse (LPN)-A verified ked and the sharps container	t			
	During a review of	medication storage on 6/10/15,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	TVILLE CARE CENT	120 FOU	RTH STREET			
		STEWAR	RTVILLE, MN 5	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 36	21610			
	container compartr unlocked and could the sharps containe easily removed from forward. Registered	orth medication cart sharps ment door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding i d nurse (RN)-B verified the and the sharps container	t			
	at 9:10 a.m., the lo sharps container co be unlocked and co exposing the sharp container was easi compartment by sli	medication storage on 6/10/15 wer level medication cart ompartment door was noted to ould easily be opened, os container. The sharps ly removed from the iding it forward. LPN-L verified sked and stated, "The door				
	LPN-B stated wher from the residents two staff to witness by either flushing th or by putting the us container. LPN-B s sharps container," container attached medication cart. W the sharps containe unlocked and the e container, LPN-B v and attempted to u	y on 6/10/15, at 9:15 a.m., n removing Fentanyl patches for disposal , the policy was for a the destruction of the patch, ne patch in the sewer system sed patch in the sharps tated, "I always put it in the pointing to the sharps to the side of the West hen asked about the door to er compartment being ease of removing the sharps rerified the door was unlocked se a key to lock it, but was ked. LPN-B stated, "This key in to lock the door."	r			
	director of nursing that the sharps cor	v on 6/10/15, at 10:05 a.m., (DON) stated he was aware tainer compartments were ed during observation, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	stated, "They shou unlocked doors on sharps containers, containers where u disposed, and this DON indicated he for the West medic was cracked, and t A policy was reque secure disposal of provided. A memo NURSES," dated 1 directed staff to ad wrap in tissue and	age 37 Id be locked." DON verified the the compartments holding the allowed access to the sharps used Fentanyl patches were had the potential for diversion. would be ordering a new door cation cart because the door the doors were to be locked. sted for ensuring safe and Fentanyl patches, and was not written by DON, to "ALL 2/16/13, was provided, and d, "When removing old patch, flush down toilet or put in when receiving Fentanyl patch	t			
21685	administrator, direc consulting pharma policies and proced medications. The I the pharmacist, co regular basis to en TIME PERIOD FO (21) days. MN Rule 4658.141 Housekeeping, Op Subp. 2. Physical including walls, floo systems, and equip continuous state of with regard to the h	R CORRECTION: Twenty-one	21685			7/16/15

Minnesc	ta Department of He	alth			101101	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF		FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 38	21685			
	by: Based on observati review, the facility f comfortable enviror chips of bathroom of (R95, R96, R75, R8 grout around a toile the wheelchair used Findings include: During an environm 06/11/2015 at 10:14	ent is not met as evidenced on, interview and document ailed to ensure a safe ment free from rust and paint door frames for 4 of 4 resident 37) rooms and in addition the t used by R11 was soiled and d by (R1) was soiled.		See POC for F465		
	R95's room, the bat floor, and the light s chipped paint exposi- colored. The heat is chipped paint. MM painting, the area a heat register are ru R96's room the bat the light switch had Verified by MM-A w 75's bathroom door	throom door jam near the witch in the bathroom had sing the metal which was rusty register in her room also had -A stated the door jams need round the light switch and the sty and need painting. hroom door jams and around paint chipped and were rusty. ho said he will paint.				
	MM-A agreed of the for painting those a R87's bathroom do chipped. MM-A ver metal door frame. R1's wheelchair wa	e chipped area's and the need				
Minnesota D STATE FOR	epartment of Health		6899		If continuatio	n sheet 39 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERLEGLA DENTIFICATION NUMBER: (X2) DATE SUPPLY A BUILDING:	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 00429 B. WING 06/17/2015 NAME OF PROVIDER OR SUPPLER STEELT ADDRESS, CITY, STATE, ZP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE (MM 55976 Image: Continued From page 39 PRECK ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, ZP CODE PRECK ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, ZP CODE 121685 Continued From page 39 PRECK ADDRESS, CITY, STATE, ADDRESS, CITY, STATE, ZP CODE Comparison of Compar	Minneso	ta Department of He	ealth				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 37EWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MM 55976 CMU ID PREEK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEEDED BY FILL (EACH CORRECTION EC) DEVICE (EACH CORRECTION EC) DE DEVICE (EACH CORRECTION) (EACH CORRECTION EC) DE DEVICE (EACH CORRECTION) (EACH CORRECTIO	NAME OF PROVIDER OR SUPPLER STREET ADDRESS. CTV, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST 120 FOURTH STREET NORTHEAST STEWARTVILLE CARE CENTER STEWARTVILLE, MM 55976 CMUID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEEDED BY FULL TAG ID PREIX (EACH DEPICIENCY MUST BE PRECEEDED BY FULL TAG ID PREIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEEDED BY FULL TAG ID PREVATION OF CORRECTION TAG PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEEDED BY FULL TAG ID PREVATION 21685 Continued From page 39 (Datast Solied areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated I hey don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs. IT Is bathroom in room had scratched up door jam. The toilets caulking was yellow and there was a yellowish discoloration on the floor around the director of nursing (DON) said the wheelchair were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning schedule. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environee. TIME PERIOD FOR CORRECTION:							
STEWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 53976 OWNERS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICENCY MUST BE PRECEEDE BY FULL TAG PHONDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEPDIENCY MUST BE TRECEEDED BY FULL TAG PHONDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEPDIENCY) OWNER (EACH CORRECTION SHOULD BE DEPDIENCY) OWNER (EACH CORRECTION (EACH CORRECTION) OWNER (EACH CORRECTION) OWNER (EACH CORRECTION) 21685 Continued From page 39 (dust/solied areas. MM-A stated 1 suppose its been a long time since the wheelchairs were suplowish discoloration on the thoor around the troilet. The bathroom had stratched up door jam. The toilet's caulking was yellow and there was a yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10.54 a.m. the director of nursing (DON) said the wheelchair were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning schedule. A maintenance policy in regards to general cleaning congliance. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance.	STEWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 53976 (M4) [D] PHEFK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEPICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEPICIENCY) 0000 (EACH CORRECTION (EACH CORRECTION) 0000 (EACH CORRECTION): The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure ongoing compliance. 00000 (EACH CORRECTION): The EACH CORRECTION: The EACH CORRECTION: THE PERIOD FOR CORRECTION: 00000 (EACH CORRECTION): 00000 (EACH CORRECTION):			00429	B. WING		06/1	7/2015
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PIEERX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSCIDENTIFYING INFORMATION) PRETX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE COMPLETE DATE 21685 Continued From page 39 21685 dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchairs are washed and there was no schedule for cleaning wheelchairs. 21685 R11's bathroom in room had scratched up door jam. The toilet's caukling was yellow and there was a yellow in discoloration on the floor around the toilet. The bathroom had a strong, old urine smell. MM-A agreed that the caukle and flooring was yellow and the bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchair were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning/repairs were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could deucate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance.	Pričejki TAG (EACH OERICENTY MUST BE PRECEDB BY FULL REGULATORY ON LSCIDENTIFYING INFORMATION) PRĚTX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPÉTE DATE 21685 Continued From page 39 21685 dust/soiled areas. MM-A stated I suppose its been a long time since the wheelchair was cleaned. He said the process is the staff bring the wheelchair to his office with a note asking maintenance to wash it. MM-A stated they don't keep track of which wheelchairs are washed and there was no schedule for cleaning wheelchairs. 21685 R11's bathroom in room had scratched up door jam. The toilet's caulking was yellow and there was a yellow in discoloration on the floor around the toilet. The bathroom smelled like urine. An interview on 06/11/2015 at 10:54 a.m. the director of nursing (DON) said the wheelchair were suppose to be on a cleaning schedule and he was not aware of the lack of wheelchair cleaning/repairs were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could deucate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance.			STEWAR	TVILLE, MN			1
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			dust/soiled areas. been a long time si cleaned. He said t the wheelchair to h maintenance to wa keep track of which there was no sched R11's bathroom in jam. The toilet's ca was a yellowish dis the toilet. The bath smell. MM-A agree was yellow and the An interview on 06 director of nursing were suppose to be he was not aware of cleaning schedule. A maintenance polic cleaning/repairs we SUGGESTED ME The administrator, designee could wo maintenance to de to ensure damaged bedroom and bath managed/repaired homelike environm could educate all a program, and could to ensure ongoing TIME PERIOD FO	MM-A stated I suppose its ince the wheelchair was he process is the staff bring is office with a note asking sh it. MM-A stated they don't n wheelchairs are washed and dule for cleaning wheelchairs. room had scratched up door ulking was yellow and there coloration on the floor around froom had a strong, old urine ed that the caulk and flooring bathroom smelled like urine. (11/2015 at 10:54 a.m. the (DON) said the wheelchairs e on a cleaning schedule and of the lack of wheelchair icy in regards to general ere requested but not received. THOD OF CORRECTION: director of nursing (DON) or rk with the director of velop a maintenance program d walls, floors, ceilings, and room fixtures are to maintain a safe, clean, ient. The DON or designee ppropriate staff on the d develop monitoring systems compliance. R CORRECTION:				
Minnesota Department of Health		winnesota D	epartment of Health					

Minneso	ta Department of He	alth			FORM APPROV	VED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00429	B. WING		06/17/2015	J
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	FB	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
21880	Continued From pa	ge 40	21880			
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880		7/16/1	5
	their stay in a facility to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fanursing home ombut Americans Act, sec posted in a conspice	inpatient facility, every				
	253C.01, every non facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires	n as defined in section hacute care facility, and every hore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written				
	an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section	ovides for a timely decision by n maker if the grievance is not Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery 144.691 and compliance by e organizations with section				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	E R	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 41	21880			
	62D.11 is deemed t requirement for a w procedure.	to be compliance with the ritten internal grievance				
	by: Based on observati review, the facility fa grievances were re-	ent is not met as evidenced on, interview and document ailed to ensure resident solved promptly for 4 of 4 6, R7 & R66) who expressed a cility staff.		See POC for F166		
	Findings include:					
	p.m. R53 reported I long. R53 stated, "S night. I've told all th I've asked if they ca nothing happens. T	with R53 on 6/8/15, at 6:05 her roommate hollers all night she sleeps all day, hollers all e nurses. Nothing gets done. an give her a private room, but hey try different stuff, it keeps me up all night. They or me."				
	5/3/15, at 1:39 a.m. "can't sleep with he from 5/3/15 at 1:46 on ss [social service that incident." On 5 note entry included was doing over by [853's medical record dated indicated R53 had reported, r hollering." Another note a.m. indicated, "message left es] telephone in regards to 5/3/15 at 5:13 a.m. a nurse's , "asked her [R53] what she R30's] bed during the night was giving her a stuffed ne wouldn't holler"				
Minnesota D		imum Data Set (MDS) dated ntact cognition with no nunication issues.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 42	21880			
		v with R46 on 6/9/15, at 09:23 different times someone e up at night."				
	at 4:43 a.m. include during the night be her awake which us	nedical record dated 5/16/15, ed, "States she can't sleep cause her roommate keeps sually sets off the alarm and vous Message left for SS."				
	4/29/15, indicated t	num Data Set (MDS) dated the resident had intact ehavioral or communication				
	p.m. R7 stated, "we	w with R7 on 6/8/15, at 6:36 e have a person (R30) next ore she goes to bed."				
	p.m. R7 said she h of nursing (DON) a night, so the DON	with R7 on 6/11/15, at 3:40 ad complained to the director bout the noise R30 made at had moved R30 to another ow in the room next to me."				
		dated 3/31/15, identified R7 n with no behavioral or ues.				
		v with R66 on 6/8/15, at 06:44 s noisy because another lady is t at night."	6			
		OS dated 4/22/15, identified the tively intact with no behavioral issues.				
		v with nursing assistant (NA)-D p.m., NA-D said, "I have heard				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21880	Continued From pa	age 43	21880			
	[R30] yells a lot at	night from the night staff."				
	licensed practical r a problem yelling a try to medicate her happens at least a roommate has said night. Everybody is	v on 6/11/15, at 2:41 p.m. nurse (LPN)-J said, "(R30) has and cries at night. The staff will and sit with her. This couple times a week. Her d she (R30) has kept her up all s aware of it, social services of nursing (DON). I don't know				
	9:55 a.m., LPN-K s but it has been a p night. She cries ou noise, about 1-2 tin	w with LPN-K on 6/12/15 at stated, "(R30) slept last night roblem with her yelling in the ut at night or at least makes nes a week. SS and the DON t is a difficult issue to resolve."				
	p.m., SS-A stated, grievances for the about (R30) crying grievance form abo grievance form on residents to use the	v with SS-A on 6/11/15 at 2:56 "I don't have any written past six months. I have heard out but I have not gotten a out it. Everyone is given a admission. We do not remind e grievance form. The staff try as fast as they can but she stil ut."				
	DON said he was r people awake at ni aware of the daytin	v on 6/11/15 at 5:24 p.m., the not aware [R30] was keeping ight but acknowledged, "I was ne noises." The DON stated he e process needed to be				
	Grievances/Compl and/or complaints	policy entitled, Filing aints indicated: "Grievances may be submitted orally or in istrator has delegated the				

	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET RTVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21880	responsibility of grid	evance and/or complaint	21880			
	grievance and/or co investigate the alleg report of such findi	cial Services. Upon receipt of a omplaint, Social Services will gation and submit a written ng to the administrator within receiving the grievance	1			
	director of nursing requirement to add	THOD OF CORRECTION: The could in-service staff on the ress resident concerns and attempt to resolve the)			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			7/16/15
	reporter who has revulnerable adult is or who has knowled has sustained a ph reasonably explain information to the co individual is a vulne the individual is adu reporter is not requ	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior ss:)			
	another facility and believe the vulnera previous facility; or (2) the reporter k	as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe s a vulnerable adult as defined	9			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAR	RTVILLE CARE CENT	FR	RTH STREET TVILLE, MN १				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	age 45	21980				
	 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte knows or has rease been made to the c (d) Nothing in thi reporter from also n agency. (e) A mandated n reason to believe the 626.5572, subdivisis (5), occurred must subdivision. If the time believes that a agency will determine the reported error w the criteria under si 17, paragraph (c), of facility may provide directly to the lead how the event mee 626.5572, subdivisis (5). The lead agen information when n the report under su This MN Requirem by: Based on observat review, the facility f allegations of maltr point (CEP) for 5 or 	s section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. Is section shall preclude a reporting to a law enforcement reporter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining its the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of		See POC for F490			

STATE FORM

LEHX11

If continuation sheet 46 of 71

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/17/2015	
		00429	B. WING			
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21980	Continued From pa	age 46	21980			
	at by licensed prace following the supper subsequently obse physically abusive however, the incide reported to the the interventions initiate A facility COMPLAI REGARDING an E completed by nursi 4/25/15. The conce NAME: [LPN-E's fin CONCERN: Upon residents from sup heard a lot of comm that the nurse [LPN at resident [R75]. V her room, she [R75 question and he sta That's when we rem situation"	observed by staff to be yelled tical nurse (LPN)-E on 4/24/15 er meal, and LPN-E was rved to be verbally and to R65 that same evening, ents were not immediately State agency, nor were ed to prevent further abuse. INT/CONCERN FORM MPLOYEE had been ing assistant (NA)-C dated ern included: "EMPLOYEE rst name] "COMPLAINT OR returning from bringing per co-worker [NA-E] and I notion/screaming. We noticed J-E] was yelling and screaming Ve tried to take her [R75] to b] asked [LPN-E] another arted yelling at her again. moved her [R75] from the				
	R75 was severely of	cognitively impaired. The MDS could hear with minimal				
	9:51 a.m., R75 was with family (F)-A. F the surveyor without	v and observations on 6/9/15 a s observed during an interview R75 conversed with F-A and ut hearing difficulty and uve to speak loudly for resident				
	D75'a aara plan dir	ected staff to provide, "Clear,				

If continuation sheet 47 of 71

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV COMPLETE	
		00429	B. WING		06/	17/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	needed to facilitate Information provide investigation of the interview conducted DON with NA-L. T included, "Spoke to Friday 4-24-15 p.m was talking to [R75 questions and as [I questions he was by yelling, and was pro-	-	21980			
	(NA-L) heard a little (certified nursing as at staff, kicking and her walker."	say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the acility.				
	DON was asked to regarding the imme allegations of abus residents to the adu and any interventio other residents, or incident. The DON the allegation involve because he had be	on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the e between LPN-E and the ministrator or State agency, ons taken to protect R75 or any investigation of the abuse confirmed he had not reported ving R75 to the State agency een more focused on the gation between LPN-E and				
	The facility COMPL	_AINT/CONCERN FORM				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
TEWAR	TVILLE CARE CENT	FR	JRTH STREET			
		STEWA	RTVILLE, MN 5	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21980	Continued From pa	age 48	21980			
	NA-C on 4/25/15 a [p.m.] I went to go and noticed reside cart arguing with [L grab the water pitc her from behind lik go over but [LPN-J tried to calm reside she was too worke During an interview regards to when he incident with R65 w	MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to went over and intervened. I ent [R65] down afterwards but d up." v on 6/11/15, at 9:34 a.m. in e was notified of the abuse which occurred on 4/24/15 afte N stated staff had placed a n his home phone following the	r			
	incident but he did morning (Saturday come to the facility The DON stated it director of nursing, administrator, or so internal investigativ designated agency Following the surve	not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, ocial worker to submit any re reports to the State 7.				
	reporting of these a verbal/physical abut the State agency (4 abuse R75 had sus was made on 6/12 plan of correction f been informed that situation existed. T the State agency in [Minnesota Depart to this writer's atter	alleged incidents of use, the DON made a report to OHFC) regarding the verbal stained on 4/24/15. The repor /15, as part of the immediate following the facility having t an immediate jeopardy the incident description sent to included: "During routine MDH ment of Health], it was brough intion that on 4/24/15, staff LPN g at resident [R75]. An incident	t I			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
STEWAI	RTVILLE CARE CENTI	= B	RTH STREET I TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
21980	another demented in the main focus of the information in regar- investigation of R65 was also agitated a responding to re-dir at resident due to h [R75] and her contin- initially combined be nurse [LPN-E] into a now reporting this p separate incident The undated policy State Agencies and included, "All allege substantiated incide immediately to the A reported to appropri- The facility had sub agency on 4/16/15, ar indicated, "[R64] w next to [F-B]As he out of the chair, [F-I forearm" R64's diagnosis, ac admission record d with functional declin quarterly Minimum 3/25/15, identified F impairment and required	resident [however, R65 was nat OHFC report and rds to R75 was to support the 5. During this incident [R75] nd following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a		DEFICIENC	·Υ)		

	ota Department of He		T			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	FB	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
21980	A review of the nurs 4/15/15, included a observed resident a recliner chair. [F-B] back down. Nurse r voice. Nurse then o the chair control ou him on the right fore called social service Administrator notifie Although the facility member striking Re not reported to the day, 4/16/15. Although R99 susta origin on 8/19/14, th administrator and s immediately. An incident report for the State agency or had occurred the pr was found in her ro assistant]. Another floor[R99] was sta her left arm. She die	sing progress notes dated note from 4:30 p.m., "Nurse attempting to get out of a attempted to tell resident to sit noted agitation in the [F-B ' s] bserved resident's [F-B] pull t of resident's hand and hit earmNurse immediately es to evaluate the situation.				
	fracture of her left s R99's record was re admission record d diagnoses including osteoporosis. The c identified R99 as ha impairment and req	indicate resident sustained a shoulder" eviewed. The resident ated 2/26/10, identified g: senile dementia and quarterly MDS dated 8/12/14, aving severe cognitive juiring limited assistance from sferring and walking.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FB	RTH STREET RTVILLE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 51	21980			
	8/19/14 at 10:30 a. resident's room an friend was laying o was standing guard her left arm and sa was made to do RG A review of the faci Investigation Repo administrator and c indicated the incide administrator on "8 reported to the Sta "8/20/14, PM."	sing progress notes dated m. included, "CNA entered this d noted that this resident's n the floor and this resident ding her left armShe guards id owe-owe when any attempt OM [range of motion]." ility's Alleged Resident Abuse rt Form, signed by the director of nursing on 8/20/14, ent had been reported to the b/20/14, AM," and had been te licensing agency on				
	of unknown origin	y was aware R98 had bruising on 8/10/14, the facility failed to strator and state agency were ly.				
	agency on 8/12/14 cares [8/10/14] res large, purple-black forearm extending finger. Has no histo	omitted a report to the State , which included: "During AM ident was discovered to have a bruise on the left medial along the left thumb and index ory of recent trauma, or falls. e to say what happened due to e."				
	admission record o resident had diagn Alzheimer's diseas 11/18/14, identified	reviewed and the resident dated 12/5/08 indicated the oses including: dementia and e. A quarterly MDS dated I R98 had severe cognitive as totally dependent on staff for y living.				
		sing progress notes dated m., indicated while morning				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
STEWAR		FR 120 FOU	RTH STREET	NORTHEAST			
		STEWAR	TVILLE, MN 5	55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	ige 52	21980				
	bruise was noted o extending along the measuring 23.5 cm 4.5 cm in width. Th indicated R98's left edematous, and the as R98 cried out wh A Skin Integrity Eve indicated the purpli- medial forearm extended	rovided, a large, purple-black n R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and e progress notes also hand and fingers were e area appeared to be tender, hen arm was moved. ents Report dated 8/10/14, sh-black bruise on R98's left ending to the side of the thumb as mildly painful and was					
	Investigation Report the administrator at 8/15/14, included: " resident's L [left] me trauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impace intra-articular exten- investigative report	not been notified of the 8/10/14					
	stated administrative to the State agency them to call me." The cell phone and staff reach him, and he the administrator. that were submitted not all been submitted administrator or Staff	6/11/15 at 9:34 a.m., the DON ve staff were to submit reports v, "Other staff can, but I want he DON stated he carried a f knew they could always would then report incidents to The DON verified the reports d for R64, R99, and R98, had ted immediately to the ate agency as required. The was aware the reports needed					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR				
(X4) ID	SUMMARY ST		RTVILLE, MN 5	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE
21980	Continued From pa	age 53	21980			
	to be submitted im have a system prol	mediately and stated, "We blem."				
	Abuse to State Age Entities/Individuals alleged/suspected incident of mistreat unknown source, o	included: "Should an violation or substantiated tment, neglect, injuries of an or abuse be suspected, it must ported to the administrator and				
	The administrator a abuse prohibition p revise as necessar the policies and pro	THOD OF CORRECTION: and designee could review policies and procedures and ry, could educate all staff on pocedures, and monitor all erable adult reports for porting.				
	TIME PERIOD FO days.	R CORRECTION: Seven (7)				
21995	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 4a Reporting - Inerable Adults	21995			6/17/15
	(a) Each facility sh ongoing written pro- applicable licensing of suspected maltro- facility has an inter- mandated reporter requirements of thi internally. Howeve responsible for com	al reporting of maltreatment. nall establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting er, the facility remains nplying with the immediate ents of this section.				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	۲ NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 54	21995			
	review, the facility f allegations of maltr Point (CEP) for 5 o	tion, interview and document failed to immediately report reatment to the Common Entry of 6 residents (R75, R65. R64, ewed for allegations of	,	See POC for F223		
	Findings include:					
	at by licensed prace following the support subsequently obse physically abusive however, the incide reported to the the	observed by staff to be yelled tical nurse (LPN)-E on 4/24/15 er meal, and LPN-E was rved to be verbally and to R65 that same evening, ents were not immediately State agency, nor were ed to prevent further abuse.				
	REGARDING an E completed by nursi 4/25/15. The conce NAME: [LPN-E's fin CONCERN: Upon residents from sup heard a lot of comm that the nurse [LPN at resident [R75]. W her room, she [R75] question and he sta	INT/CONCERN FORM MPLOYEE had been ing assistant (NA)-C dated ern included: "EMPLOYEE rst name] "COMPLAINT OR returning from bringing per co-worker [NA-E] and I motion/screaming. We noticed V-E] was yelling and screaming Ve tried to take her [R75] to 5] asked [LPN-E] another arted yelling at her again. moved her [R75] from the				
	5/12/15 indicated F mental status (BIM R75 was severely of	nimum data set (MDS) dated R75 had a brief interview for IS) score of 4 which indicated cognitively impaired. The MDS could hear with minimal	3			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN &				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 55	21995				
	 9:51 a.m., R75 was with family (F)-A. F the surveyor without surveyor did not had to hear. R75's care plan dir careful, explanation comprehensionref needed to facilitate Information provide investigation of the interview conducted DON with NA-L. T included, "Spoke t Friday 4-24-15 p.m was talking to [R75] questions and as [I questions he was by yelling, and was proshould. [R65] was set the surveyor did not had be are the surveyor of the survey of the survey	epeat/rephrase words as hearing and comprehension." ed by the DON related to the se incidents, included a typed d 4/25/15 at 10:00 a.m., by the he interview documentation o [NA-L] concerning incident i. shift. She stated he [LPN-E] i]. [R75] was repeating _PN-E] was answering becoming more upset and obably yelling more than he standing nearby with her					
	(NA-L) heard a little (certified nursing as at staff, kicking and her walker."	say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with					
		ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the acility.					
	DON was asked to regarding the imme allegations of abus	v on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the e between LPN-E and the ministrator or State agency,					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 56	21995			
	other residents, or incident. The DON the allegation invol- because he had be	ns taken to protect R75 or any investigation of the abuse confirmed he had not reported ving R75 to the State agency en more focused on the gation between LPN-E and	1			
	REGARDING an E NA-C on 4/25/15 a [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitcl her from behind like go over but [LPN-J	AINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but d up."				
	regards to when he incident with R65 w evening meal, DON phone message or incident but he did morning (Saturday come to the facility The DON stated it director of nursing, administrator, or so	y on 6/11/15, at 9:34 a.m. in a was notified of the abuse which occurred on 4/24/15 after stated staff had placed a his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, ocial worker to submit any re reports to the State				
	reporting of these a verbal/physical abuthe State agency (eyor's inquiry about the alleged incidents of use, the DON made a report to DHFC) regarding the verbal stained on 4/24/15. The report				

	ota Department of He						
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		- 06/17/2		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
STEWAR	RTVILLE CARE CENTI	-8	TH STREET VILLE, MN &	NORTHEAST 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21995	was made on 6/12/ plan of correction for been informed that situation existed. The the State agency in [Minnesota Departm to this writer's atten [LPN-E] was yelling was initially reported another demented of the main focus of the information in regar investigation of R65 was also agitated a responding to re-dir at resident due to h [R75] and her contin- initially combined bonurse [LPN-E] into on now reporting this p separate incident The undated policy State Agencies and included, "All allege substantiated incided immediately to the A reported to appropri- The facility had sub agency on 4/16/15, ar indicated, "[R64] w next to [F-B]As here	15, as part of the immediate ollowing the facility having an immediate jeopardy he incident description sent to cluded: "During routine MDH nent of Health], it was brought tion that on 4/24/15, staff LPN at resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was hat OHFC report and ds to R75 was to support the 5. During this incident [R75] nd following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a	21995				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	_		
STEWAE		ER 120 FOU	RTH STREET	NORTHEAST			
		STEWAR	TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	ge 58	21995				
	admission record d with functional decl quarterly Minimum 3/25/15, identified F impairment and rec from one person fo (ADL)'s. A review of the nurs 4/15/15, included a observed resident a recliner chair. [F-B] back down. Nurse r voice. Nurse then o the chair control ou him on the right fore called social service Administrator notifie	cording to the resident ated 1/21/15, included debility ine and dementia. The Data Set (MDS) dated R64 had severe cognitive quired extensive assistance r all activities of daily living sing progress notes dated note from 4:30 p.m., "Nurse attempting to get out of a attempted to tell resident to sin noted agitation in the [F-B ' s] observed resident's [F-B] pull t of resident's hand and hit earmNurse immediately es to evaluate the situation. ed as well."	t				
	not reported to the day, 4/16/15.	54 on 4/15/15, the incident was State agency until the next ained an injury of unknown					
		ne facility failed to ensure the tate agency were notified					
	the State agency or had occurred the provide the provided th	or R99 had been submitted to n 8/20/14 for an incident that revious day, "Res [resident] om by a CNA [certified nursing residentwas lying on the anding in the room guarding d complain of pain. Res was ncy Room for xray and indicate resident sustained a					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
TEWAR	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21995	Continued From pa	age 59	21995				
	admission record d diagnoses including osteoporosis. The identified R99 as have impairment and record one person for trans A review of the nurs 8/19/14 at 10:30 a. resident's room and friend was laying of was standing guard her left arm and sa was made to do RC A review of the faci Investigation Report administrator and c indicated the incide administrator on "8	eviewed. The resident lated 2/26/10, identified g: senile dementia and quarterly MDS dated 8/12/14, aving severe cognitive quiring limited assistance from isferring and walking. sing progress notes dated m. included, "CNA entered this d noted that this resident's n the floor and this resident ding her left armShe guards id owe-owe when any attempt DM [range of motion]." lity's Alleged Resident Abuse rt Form, signed by the director of nursing on 8/20/14, ent had been reported to the /20/14, AM," and had been te licensing agency on					
	"8/20/14, PM." Although the facility of unknown origin of	y was aware R98 had bruising on 8/10/14, the facility failed to strator and state agency were					
	agency on 8/12/14, cares [8/10/14] resi large, purple-black forearm extending finger. Has no histo	omitted a report to the State , which included: "During AM ident was discovered to have a bruise on the left medial along the left thumb and index ory of recent trauma, or falls. e to say what happened due to e."					
	R98's record was r	eviewed and the resident					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	TVILLE CARE CENT	120 FOU	RTH STREET	NORTHEAST		
		STEWAR	RTVILLE, MN 5	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	age 60	21995			
	resident had diagn Alzheimer's diseas 11/18/14, identified impairment and wa all activities of daily A review of the nur 8/10/14 at 12:40 p. cares were being p bruise was noted of extending along the measuring 23.5 cm 4.5 cm in width. The indicated R98's left edematous, and th as R98 cried out w A Skin Integrity Eve indicated the purpli medial forearm ext	dated 12/5/08 indicated the oses including: dementia and ie. A quarterly MDS dated I R98 had severe cognitive as totally dependent on staff for y living. sing progress notes dated .m., indicated while morning provided, a large, purple-black on R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and he progress notes also t hand and fingers were he area appeared to be tender, when arm was moved. ents Report dated 8/10/14, ish-black bruise on R98's left tending to the side of the thumb was mildly painful and was				
	A review of the fact Investigation Repo the administrator a 8/15/14, included: ' resident's L [left] m trauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impact intra-articular exter investigative report	not been notified of the 8/10/14				
		n 6/11/15 at 9:34 a.m., the DON ve staff were to submit reports	1			

	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING	B. WING		17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995		ige 61 v, "Other staff can, but I want	21995			
	them to call me." T cell phone and staf reach him, and he the administrator. that were submitted not all been submit administrator or Sta DON confirmed he	he DON stated he carried a f knew they could always would then report incidents to The DON verified the reports d for R64, R99, and R98, had ted immediately to the ate agency as required. The was aware the reports needed mediately and stated, "We				
	Abuse to State Age Entities/Individuals alleged/suspected incident of mistreat unknown source, o	included: "Should an violation or substantiated ment, neglect, injuries of an r abuse be suspected, it must orted to the administrator and				
	The administrator a abuse prohibition p revise as necessar the policies and pro	THOD OF CORRECTION: and designee could review olicies and procedures and y, could educate all staff on ocedures, and monitor all orable adult reports for porting.				
	TIME PERIOD FOI days.	R CORRECTION: Seven (7)				
22000		6.557 Subd. 14 (a)-(c) Itment of Vulnerable Adults	22000			7/16/15
	facility, except hom personal care atter	prevention plans. (a) Each e health agencies and Idant services providers, shall ce an ongoing written abuse				

MILLINESC	ota Department of He	aith	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/20	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTI	-B	RTH STREET I TVILLE, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
22000	Continued From pa	ge 62	22000			
	assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, i agency and person providers, shall dev prevention plan for residing there or reacting there will be adults; (i) other vulnerable adults; (i) other vulnerable adults. For the purpterm "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an atoward others, the i plan must detail the minimize the risk there asonably be expected facility and persons unsupervised. Und of a vulnerable adult misconduct or physisuch information from authority or through	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the les self-abuse. except home health agencies attendant services providers, erable adult has committed a act of physical aggression ndividual abuse prevention e measures to be taken to the vulnerable adult might ected to pose to visitors to the outside the facility, if ler this section, a facility knows It's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by other health care provider, or				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	
		00429	B. WING		06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STEWAR		FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa vulnerable adult. This MN Requirement	ge 63 ent is not met as evidenced	22000			
	Based on interview facility failed to imp policies and proced reporting of alleged administrator and S resident/s from ong thorough investigat abuse/neglect for 5 R64, R99, R98) wh prohibition. This ha	and document review, the lement their abuse prohibition lures related to immediate abuse/neglect to the State agency, protecting ioing abuse, and completing a ion following an allegation of of 26 residents (R75, R65, o were reviewed for abuse d the potential to affect all 68 residing in the facility.		See POC for F490		
	Findings include:					
		ity provided a package of Procedure Standards related n:				
	and Symptoms of A personnel are to re- of abuse/neglect to director of nursing s the Administrator." and symptoms of a promptly. The proce physical abuse, sig and signs/symptom abuse/neglect.					
Vinnesota D	The undated policy Reporting/Investiga					

ATEMENT OF DE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
	R OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
EWARTVILL	E CARE CENT	FR	RTH STREET I RTVILLE, MN 5			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
22000 Conti	nued From pa	age 64	22000			
involv of nu admin "all ad thoro findin	ing residents sing services histrator." Th ccidents/incide ughly investig	s read, "All accidents/incidents must be report to the director and immediately to the procedure directed staff that ents involving residents will be ated by management and the vestigation will be kept on file Nursing."				
Inves or ne- inves admin inves repor the in that e reside nonre result	tigation read, glect shall be tigated." The nistrator would tigate the inci- t daily to the a vestigation. The mployees that ent abuse would sident care d	r entitled Abuse and/or Neglect "All reports of resident abuse promptly and thoroughly procedure directed the d appoint a designee to dent and that person would administrator the progress of The procedure also directed at had been accused of uld be reassigned to uties or put on leave until the tigation had been reviewed by				
Resic facilit inves proce inves abuse duties reass assig buildi proce	lents During A y will protect r tigations of at dure directed tigations, emp would be rea or put on lea igned to non- nments would ng which the dure read, "S o occurred, ap	v entitled Protection of Abuse Investigation read, "Our residents from harm during buse allegations." The that during abuse bloyees accused of resident assigned to nonresident care ave; and that if employees were resident care duties, such a not be in any part of the resident frequents. The should the results indicate that ppropriate authorities will be	9			
		ventitled Reporting Abuse to d Other Entities/Individuals				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
STEWAR	RTVILLE CARE CENT	-8	RTH STREET I				
		STEWAR	TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	ge 65	22000				
	read, "All alleged/su substantiated incide immediately to the A reported to appropr procedure directed alleged/suspected v incident of mistreatu unknown source, or must be immediate and to proper state Social Services 2. M Health/OHFC. B. V above agencies will following the incider administrator, or his internal investigatio working days of the R75 was observed by licensed practica The incident was no administrator or des was R75 protected thorough investigati A facility COMPLAII REGARDING an El completed by nursin The concern include [LPN-E's first name CONCERN: Upon r residents from supp heard a lot of comm that the nurse [LPN at resident [R75]. W her room, she [R75] question and he sta	Ispected violations and all ents of abuse will be reported Administrator and promptly iate state agencies. The "A. Should an violation or substantiated ment, neglect, injuries of r abuse to be suspected. It ly reported to the administrator agencies 1. Olmsted County //innesota Department of 'erbal/written notices to the be made immediately nt if possibleC. The s/her designee, will submit n report to OHFC website 5 occurrence of the incident." to have been verbally abused al nurse (LPN)-E on 4/24/15. ot immediately reported to the signated State agency, nor following this incident, or a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00429	B. WING	B. WING		06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 66	22000				
	DON was asked fo immediate reportin administrator, OHF protect R75 from fur residents and a tho abuse incident. No stated he did not re- separately but was in regards to the ph DON stated he was abuse incident with physical abuse of R7 the evening meal a medications.	a on 6/12/15, at 9:30 a.m., the r all information regarding the g of the verbal abuse to the C, and interventions taken to urther abuse as well as other prough investigation of the ne was provided and the DON eport this incident with R75 with the report sent to OHFC hysical abuse to R65. Then the s more focused on the physica R65 at the time. Again the R65 occurred shortly after the 5 by LPN-E on 4/24/25 after is LPN-E was passing	,				
	record until two day "Several staff mem conference room w voice towards resid indicated notificatio	ys later on 4/27/15 and read, bers were in the south when a staff nurse heard raising dent." The progress note also on of DON, ADON, and Social did not indicate when the	3				
	OHFC and to the C 6/12/15 after the su	the verbal abuse of R75 to the Common Entry Point (CEP) on urvey team had informed the te jeopardy (IJ) related to					
	LPN-E on 4/24/15	pally and physically abused by however, this was not ed to the administrator or					
	REGARDING an E	AINT/CONCERN FORM MPLOYEE completed by Iso included:"Around 7:40					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/17/2015	
		00429	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	[p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitcl her from behind lik go over but [LPN-J tried to calm reside she was too worke A typed witness act that occurred on 4/ investigation for Re LPN-J read, "On Fi staff potluck,He medication admin a grabbed the water it. He grabbed it ou on cart. She then ra him with it, not sure dropped it but it fell up and [R65] went fist at which time I [R65] to leave the a shortly after that." The facility provide submission report of Health Facility C investigative notes. complaint, the allegt had been reported R64 had an allegat	ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but	t	DEFICIENC	27)	
	family (F) member however, it was not until the next day. The facility submitt on 4/16/15 indicatir		/			

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• •	
TEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 68	22000			
	around 4:40 p.m. "[R64] was sitting in a reclining chair next to [F-A] As he was attempting to get up and out of the chair, [F-A] struck him on the forearm"					
	4/15/15, at 4:30 p.r resident attempting [F-A] attempted to Nurse noted agitati then observed resid control out of resid right forearmNurs	sing progress notes, dated m., included, "Nurse observed g to get out of a recliner chair. tell resident to sit back down. ion in the [F-A]'s voice. Nurse dent's [F-A] pull the chair ent's hand and hit him on the se immediately called social e the situation. Administrator				
	causing a fracture	an injury of unknown origin the facility did not immediately to the state agency.				
	agency on 8/20/14 found in her room I assistant]. Another floor [R99] was s her left arm. She d sent to the Emerge	for R99, submitted to the State indicated, "Res [resident] was by a CNA [certified nursing residentwas lying on the tanding in the room guarding id complain of pain. Res was ency Room for xray and indicate resident sustained a shoulder"				
	8/19/14 at 10:30 a. this resident's room friend was laying o was standing guard her left arm and sa	sing progress notes dated m., included: "CNA entered n and noted that this resident's n the floor and this resident ding her left armShe guards id owe-owe when any attempt DM [range of motion]."				
	Investigation Repo	ility's Alleged Resident Abuse rt Form, signed by the				
TE FOR	epartment of Health VI		⁶⁸⁹⁹ LE	EHX11	If continuation	on sheet 69 d

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NU					E SURVEY PLETED		
		00429			06/	06/17/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	B. WING 06/17/201 ADDRESS, CITY, STATE, ZIP CODE					
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN {					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
22000	Continued From pa	age 69	22000					
	indicated the incide reported to the adm	director of nursing on 8/20/14, ent from 8/19/14 had first been ninistrator on "8/20/14, AM," ntly been reported to the State on "8/20/14, PM."						
	forearm which was however, this was State agency or the	have a large bruise on her left found to be a fracture not immediately reported to the administrator as directed by olicy and procedure.	•					
	on 8/12/14, which i [8/10/14] resident v purple-black bruise extending along the Has no history of re	ed a report to the state agency included: "During AM cares was discovered to have a large on the left medial forearm e left thumb and index finger. ecent trauma, or falls. Resident what happened due to se."	,					
	8/10/14 at 12:40 p. cares were being p bruise was noted o extending along the measuring 23.5 cm 4.5 cm in width. Als and fingers were en	sing progress notes dated m., indicated while morning provided, a large, purple-black on R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and so included, R98's left hand dematous, and the area ider, as R98 cried out when						
	Investigation Repo administrator and o included: "Unexpla L [left] medial forea area. Discomfort no motion]. Seen by N	ility's Alleged Resident Abuse rt Form, signed by the director of nursing on 8/15/14, ined bruise noted on residents arm. No history of trauma to oted with gentle ROM [range o IP [nurse practitioner] on ordered. Results show a						

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00429	00429 B. WING				
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
STEWAR	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 70	22000				
	intra-articular exter	ted fracture distal radius with nsion and osteoporosis" Also nistrator was not notified until					
	of unknown origin	y was aware R98 had bruising on 8/10/14, the facility failed to strator and State agency were y.					
	director of nursing administrative staff State agency and s want them to call m cell phone and staff reach him, and he the administrator. If were submitted for submitted immedia agency and were m immediately to the he was aware the m	h 6/11/15, at 9:34 a.m. the (DON) indicated the were to submit reports to the stated, "Other staff can, but I he." DON stated he carried a if knew they could always would then report incidents to DON verified the reports that R64, R99, and R98, were not ttely, as required, to the State not always reported administrator. DON indicated reports needed to be submitted ated, "We have a system					
	prohibition policies necessary, could e and procedures, ar	RRECTION: The designee could review abuse and procedures and revise as ducate all staff on the policies nd monitor all incidents and ports for compliance with					
	TIME PERIOD FO days.	R CORRECTION: Seven (7)					

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing	Y	2	8/11/2015	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
STEWARTVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST			
		STEWARTVILLE, MN 55976			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #		(b), 483.13(c)(1)(i)	Correction Completed	ID Prefix Reg. #	F0225 483.13(c)(1)(ii)-(ii - (4)	i), (c)(2)	Correction Completed
LSC			07/16/2015	LSC			06/17/2015	LSC			06/17/2015
ID Prefix	F0226		Correction	ID Prefix	F0247		Correction	ID Prefix	F0250		Correction
Reg. #	483.13(c)		Completed	Reg. #	483.15	(e)(2)	Completed	Reg. #	483.15(g)(1)		Completed
LSC			06/17/2015	LSC			07/27/2015	LSC			07/27/2015
ID Prefix	F0279		Correction	ID Prefix	F0280		Correction	ID Prefix	F0309		Correction
Reg. #	483.20(d), 483.	20(k)(1)	Completed	Reg. #	483.20(d)(3), 483.10(k) (2) Completed Reg. #		483.25		Completed		
LSC			07/17/2015	LSC 07/17/2015 LSC			07/16/2015				
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.25(h)		Completed	Reg. #	483.25	(i)	Completed	Reg. #	483.60(b), (d), (e)		Completed
LSC			07/17/2015	LSC			07/17/2015	LSC			07/17/2015
ID Prefix Reg. #	F0441 483.65		Correction Completed	ID Prefix F0465 Reg. #			Correction Completed	ID Prefix Reg. #	F0497 483.75(e)(8)		Correction Completed
LSC			07/17/2015	LSC			07/16/2015	LSC			07/27/2015
REVIEWI STATE A		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEW	ED BY	REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/17/2015					RANY UNCORRECTED DEFICIENCI					s 🗌 no	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /			DATE OF REVISIT		
IDENTIFICATION NUMBER	A. Building			1	
00429 _{Y1}	B. Wing	,	Y2	8/11/2015	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
STEWARTVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST			
		STEWARTVILLE, MN 55976			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
			15	14			15	14			15
ID Prefix	20285		Correction	ID Prefix	20302		Correction	ID Prefix	20560		Correction
Reg. #	MN Rule 4658.0 Subp. 2	100	Completed	Reg. #	MN Sta 144.65	ate Statute 03	Completed	Reg. #	MN Rule 4658.0405 Subp. 2		Completed
LSC			07/27/2015	LSC			07/27/2015	LSC			07/17/2015
ID Prefix	20570		Correction	ID Prefix	20830		Correction	ID Prefix	20965		Correction
Reg. #	MN Rule 4658.0 Subp. 4	405	Completed	Reg. #	MN Ru Subp.	le 4658.0520 1	Completed	Reg. #	MN Rule 4658.06 Subp. 2	00	Completed
LSC			07/17/2015	LSC			07/16/2015	LSC			07/17/2015
ID Prefix	21375		Correction	ID Prefix	21426		Correction	ID Prefix	21495		Correction
Reg. #	MN Rule 4658.0 Subp. 1	800	Completed	Reg. #	MN St. Subd. 3	Statute 144A.04	Completed	Reg. #	MN Rule 4658.1005 Subp. 5		Completed
LSC			07/17/2015	LSC			08/11/2015	LSC			07/27/2015
			0				o				.
ID Prefix			Correction	ID Prefix			Correction	ID Prefix	21880		Correction
Reg. #	MN Rule 4658.1 Subp. 1	340	Completed	Reg. #	MN Ru Subp. 2	le 4658.1415 2	Completed	Reg. #	MN St. Statute 144.651 Subd. 20		Completed
LSC			07/17/2015	LSC			08/11/2015	LSC			07/16/2015
ID Prefix	21980		Correction	ID Prefix	21995		Correction	ID Prefix	efix 22000		Correction
Reg. #	MN St. Statute 6 Subd. 3	626.557	Completed	Reg. #	MN St. Subd.	Statute 626.557 4a	Completed	Reg. #	MN St. Statute 6 Subd. 14 (a)-(c)	26.557	Completed
LSC			06/17/2015	LSC			06/17/2015	LSC			06/17/2015
REVIEW		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE			DATE		
FOLLOWUP TO SURVEY COMPLETED ON 6/17/2015					RANY UNCORRECTED DEFICIENCI				□ YE	s 🗌 no	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

December 18, 2015

Rebecca K. Coffin Voigt, Rode and Boxeth, LLC 2550 University Avenue West Suite 190 South St. Paul, MN 55114

RE: Docket OAH 60-0900-32874

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Stewartville Care Center in Stewartville, MN, regarding five federal deficiencies issued as a result of a recertification survey, exit date June 17, 2015. The IIDR was held before Administrative Law Judge James E. LaFave. The Department received Judge LaFave's recommended decision the afternoon of December 8, 2015.

Decision

After careful review of Judge LaFave's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with rescinding tags F223, F225 or F226, and uphold them as written. F223 and F225 were written at a scope and severity of Level K, and F226 was issued at a scope and severity of F. I concur with rescinding tags F490 and F493.

Rationale

During Stage 1 of the survey, the Abuse Task was triggered. When a task is triggered, a surveyor follows a specific pathway – an established and computer directed set of investigative protocols, to investigate whether there was a deficient practice in the task area. The tags issued in this survey are a result of the extended survey that was conducted as a result of the triggering of the Abuse Task.

It is not disputed that the incidents in this IIDR occurred. What is disputed is the conclusion of Stewartville's internal investigation of the incidents, the incomplete manner in which the internal investigations were conducted, the sequence and timing of reporting the incidents to the State Agency (Office of Health Facility Complaints - OHFC), and the accuracy of the

Ms. Rebecca K. Coffin Page 2 December 18, 2015

information on the reports to the OHFC when compared to the information in the facility's incident files.

Tag F223 requires a resident has *the right* to be free from *verbal*, sexual, *physical and mental abuse*, corporal punishment, and involuntary seclusion. The intent of the regulation is that residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Interpretive Guidelines include a definition of abuse: "abuse" means the willful infliction of injury, unreasonable confinement, *intimidation*, or punishment with resulting physical harm, pain or *mental anguish*." (42 CFR §488.301) The Interpretive Guidelines, further define types of abuse: verbal abuse, sexual abuse, physical abuse, mental abuse and involuntary seclusion. "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse *include*, *but are not limited to*: threats of harm; *saying things to frighten a resident*, such as telling a resident that he/she will never be able to see his/her family again. "Mental abuse" *includes, but is not limited to humiliation*, harassment, and threats of punishment or deprivation.

The surveyor found two facility incident reports involving R65 and R75 with allegations of physical and verbal abuse involving LPN-E. Both incidents occurred on April 24, 2015.

R65 was a cognitively impaired resident, who exhibited short and long term memory loss. R65 exhibited behavioral symptoms including paranoia and at times was physically resistive with cares. R65 could usually make her needs known and could walk independently with a wheeled walker.

R75 was cognitively impaired with short and long term memory loss. R75 did not have a history of abusing others, had adequate hearing at a normal level of conversation and was able to express her needs verbally.

The facility contends that LPN-E did not verbally abuse R75, rather he was speaking loudly so R75 could hear him. The facility noted it suspended LPN-E pending further investigation of R65 and reported the incident to the OHFC. After conducting its internal investigation, Stewartville concluded LPN-E was trying to keep R65 safe and prevent her from harming herself or others. They concluded that LPN-E did not abuse R65 or intend to harm her in any way.

The Centers for Medicare and Medicaid (CMS) require surveyors to follow Interpretive Guidelines when determining whether a deficient practice exits. When looking at allegations of potential abuse to residents, all possible types of abuse must be considered. While the term "willful infliction of" is used in the definition of abuse, it is not further defined in the Interpretive Guidelines at F223. "Willful" is defined in the State Operations Manual in Appendix Ms. Rebecca K. Coffin Page 3 December 18, 2015

PP, Interpretive Guidelines for an abuse and supervision tag as: "means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish." The New World Dictionary of the American Language defines "willful" as: "1. said or done deliberately or 2. Following one's own will unreasoningly; obstinate; stubborn." Raising one's voice very loudly, or yelling at a resident to be heard, seeing the resident is further distressed as a result of that action and yet continuing the action is a willful act, it is an action committed unreasoningly. Moreover, there were several staff onsite (RN-H, LPN-J, NA-E, NA-C) at the time who overheard the loud interaction between LPN-E and R75. These staff were concerned enough by the interaction to leave areas they were working in such as the dining room, hallway, and other resident rooms, to check out what was happening. These other staff who were familiar with LPN-E and R75, did not consider the interaction to be "normal", that is, that LPN-E was speaking loudly in an attempt to allow R75 to hear him. RN-H was concerned enough by this observation that she immediately called the assistant director of nursing to report she was concerned about LPN-E's "mental state." The other staff were concerned enough about the incident to file facility Complaint/Concern Forms Regarding Employee, one included: "Upon returning from bringing residents from supper, co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at [R75]. We tried to take her to her room. She [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation around 7:40. I went to go ask nurse [LPN- J] a question and noticed [R65] standing by med cart arguing with [LPN-E]. She attempted to grab water pitcher and he grabbed her from behind like choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident down afterwards but she was too worked up."

The nursing assistant who documented the Complaint/Concern report noted above was listed as a witness in the investigative report the facility sent into the OHFC as required; however, that report did not provide this firsthand witnesses' account as stated above. Instead the report to OHFC included: "During routine MDH survey it was brought to this writer's attention that on 4-24-15, staff [LPN-E] was yelling at [R75]. This incident was initially reported regarding another demented resident. During this incident [R75] was also agitated and following the nurse and not responding to redirection. [LPN-E] did yell at resident due to his frustration with [R65] and her continued agitation. This writer initially combined both of these actions by [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident. [R75] has not suffered any negative effects from this situation and continues to wander the facility in her w/c as usual."

The other nursing assistant who had witnessed this incident, and who was referenced in the Complaint/Concern report, was not interviewed by the facility during the investigation of the incident. According to the CMS 2567, Statement of Deficiencies, R75 conversed with survey staff during the survey and was able to do so without hearing difficulty. Additionally, the

Ms. Rebecca K. Coffin Page 4 December 18, 2015

facility's care plan indicated that although R75 had some hearing loss, her hearing was adequate at a normal level of conversation.

The initial incident report related to R65, submitted by the facility on 4/25/15 omitted the above interaction between LPN-E and R75 entirely. In addition, there was no reference to eyewitness NA-C's description of R65 having been placed in a "choke hold". The initial incident report also indicated R65 experienced no injuries, however facility progress notes indicated R65 had swelling and pain in her left thumb and had received pain medications for the discomfort. R65 was examined by her nurse practitioner for an "evaluation after physical assault" on 4/28/15 when bruising was noted to R65's left thumb web space.

LPN-E was observed in the facility on 6/9/15 during a medication pass. This observation occurred three days prior to the survey team identifying the immediate jeopardy on 6/12/15. This statement is included in the CMS 2567 to verify LPN-E was observed at the time of survey and had continued to remain a direct patient caregiver. LPN-E was not interviewed after the IJ was called because he had been removed from the facility's work schedule after 6/11/15. The facility was in an immediate jeopardy (IJ) and working to abate the IJ by conducting its own internal investigation, which involved LPN-E. The MDH could not interfere with that investigation. In addition, written statements by LPN-E about the incidents provided to the survey team acknowledge LPN-E was frustrated at the time the incidents occurred and that he could have handled the situation better, confirming that his loud volume was not appropriate and the resident responded negatively. In an undated document provided by LPN-E to the facility as part of the initial investigation into R65's incident LPN-E stated, "I know confronting anyone in her [R65's] condition is not the way to handle these situations but sometimes cercomstances [sic] prevent the ideal situation." The follow up investigation report submitted to OHFC by the DON on 4/29/15 indicated LPN-E "admits he could have handled the situation differently, and understands that his response was inappropriate."

This deficiency is properly cited at a Level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

Tag F225 requires that the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported *immediately* to the administrator of the facility *and* to other officials in accordance with state law through established procedures (including to the state survey and certification agency), and the facility must have evidence that all alleged violations are *thoroughly* investigated, and *must prevent further potential abuse* while the investigation is in progress.

The facility's investigation into R65's incident of alleged physical abuse included written statements and interviews with some, but *not all*, staff present at the time of the incident. The

Ms. Rebecca K. Coffin Page 5 December 18, 2015

investigation included an interview with R65, who was unable to recall the details of the incident. This investigation was submitted to OHFC on 4/29/15. The investigation minimized the severity of the situation by indicating R65 had not experienced any injuries as a result, lacked information concerning an allegation of mistreatment towards R75 on the same evening, and lacked an eyewitness description from NA-C describing R65 being put in a choke hold. The investigative report indicated LPN-E had not had any prior allegations of abuse, however LPN-E had a verbal allegation of abuse that very same evening just prior to R65's incident. No interviews were conducted with other residents LPN-E cared for, to determine the extent of his misconduct or if other residents had been affected in the past or if there was indeed a history of inappropriate behavior on LPN-E's part. R75's incident of alleged mistreatment was not investigated by the facility until it was identified by the survey team.

R98 exhibited bruising and signs of injury to her left forearm on 8/10/14. R98 was physically dependent on staff in all aspects of her care, was cognitively impaired and required a mechanical lift for transfers. An x-ray taken after the injury was identified revealed a comminuted fracture of the distal radius. The facility investigative report submitted to OHFC on 8/15/14 included interviews with the resident's roommate, and staff who had cared for R98 for the previous 24 hours. The investigative report concluded: "Reasonable explanation of comprehensive investigation results indicates that resident's incident was a result of therapeutic conduct during the normal course of care." The investigative report lacked interviews with other staff members beyond the immediate 24 hour window, and assumed the care plan was followed without a review of all of the circumstances present. The investigative report also lacked a review of the medical record, to identify whether R98 had signs of pain prior to the incident or any other details in an attempt to identify a specific timeframe for when the injury had occurred.

R99 sustained a fractured left shoulder on 8/19/14. R99 was a cognitively impaired individual who was independent in ambulation with the use of a walker, and was determined by the facility not to be a reliable reporter of maltreatment. R99 did not have a history of abuse towards others. R99 had been found by facility staff in her room holding her left shoulder. Another resident, a friend of R99's was found on the floor lying alongside her. The facility's investigative report, submitted to OHFC on 9/21/14 indicated the facility interviewed R99's friend, who also was cognitively impaired and stated R99 "fell in the yard the other day." The investigative report indicated other residents and family in the area were interviewed and did not notice anything out of the ordinary. The investigative report does not include interviews with facility staff that had contact with R99 at the time of the incident or prior to the event, and concludes that "Comprehensive investigation results indicate that resident was injured in the course of attempting to help her friend." There is no evidence to suggest there was a review of circumstances surrounding the incident, including a review of the immediate environment to further identify how R99 may have fallen or injured herself.

Ms. Rebecca K. Coffin Page 6 December 18, 2015

There is no evidence in the facility records that these incidents were thoroughly investigated. Stewartville Care Center's policies, entitled Abuse and/or Neglect Investigation indicate investigations should include interviews with other residents in which the employee provides care or services, review of all circumstances surrounding the incident, interviews with all staff having contact with the resident during the period of the alleged incident, and interviews with the resident's roommate, family member and visitors and a review of the resident's medical record.

This deficiency is properly cited at a level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

F226 requires that the facility must develop and *implement* written policies and procedures that *prohibit mistreatment*, neglect, and *abuse* of residents and misappropriation of resident property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences of resident *abuse*, neglect, *mistreatment* and misappropriation of property.

R65's investigative report which was submitted to OHFC on 4/29/15, indicated LPN-E would have follow up with the facility social worker related to his approach in caring for cognitively impaired residents with behaviors. There is no evidence this follow up took place to ensure LPN-E's conduct with R65 remained appropriate. The facility's policy, entitled Preventing Resident Abuse included an intervention of including "scheduled in-service training programs designed to teach staff how to better understand the resident's abusive actions." There was no evidence this training was provided to LPN-E, or to newly hired staff whose employment files had been reviewed during the survey. LPN-E did not receive specific training related to care of residents with behaviors until 4/25/15 although he had been employed at the facility since 1/14.

F226 was cited as an "independent but associated deficiency" citation. The MDH is expected to cite deficient practices at all appropriate regulatory requirements. F226 was cited for the facility's failure to *fully operationalize* its abuse/neglect policy with respect to the immediate reporting of abuse, neglect, mistreatment and misappropriation of property, failure to educate staff related to management of residents with behaviors, failure to fully investigate incidents of alleged abuse and failure to protect residents after alleged incidents of abuse occurred. This was evidenced by the failure to immediately *report* the allegation of mistreatment towards R75 to OHFC and complete a *thorough* investigation in a timely manner. Additionally, the facility failed to remove LPN-E from direct patient care after this incident occurred. This constituted a failure to *protect* residents from further abuse, and resulted in a second allegation the same evening with R65. In R65's situation, the facility failed to *conduct a thorough investigation*, including interviewing all potential witnesses to the events and other residents to determine

Ms. Rebecca K. Coffin Page 7 December 18, 2015

the extent of LPN-E's misconduct. Subsequent investigative reports to OHFC lacked pertinent, critical details related to eyewitness descriptions of the incidents and injury to the resident. R98 and R99 sustained fractures that were not *thoroughly investigated* as discussed at F225 and directed by the facility's policies. Lastly, Stewartville Care Center failed to ensure LPN-E and other direct caregivers employed at the facility received the necessary *training* related to management of behaviors, in an attempt to *prevent* abuse from occurring within the facility. Evaluation of the facts and the staff's actions related to these incidents represents a systemic failure on the part of the facility to implement their policies at multiple levels.

The deficiency is properly cited as an independent but associated deficiency at Level F: a widespread practice with no actual harm, and potential for more than minimal harm that is not immediate jeopardy.

F490 and F493 were cited as "independent but associated deficiencies." There were undated policies in place for all of the components of tags F223, F225 and F226. While the internal investigations were not thorough and the information submitted to OHFC was not comprehensive and reflective of the information the facility had in its file, the administrator and governing body were receiving notification of alleged incidents and investigative reports that appeared to be timely and complete. The expectation that the administrator and governing body would have knowledge, prior to this survey, of the inadequacy of the investigations, and the timeliness and sequencing of reporting and investigating, is not supported by the record. These deficiencies should be rescinded.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H. Commissioner P.O. Box 64975 St. Paul, MN 55164-0975

cc: Judge James LaFave Jan M. Suzuki, CMS Region V Cheryl Hennen Darcy Miner Holly Kranz Monica Larson

OAH 60-0900-32874

THIS DOCUMENT CONTAINS NOT PUBLIC DATA

STATE OF MINNESOTA OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the IIDR of Stewartville Care Center

RECOMMENDED DECISION

This matter came before Administrative Law Judge James E. LaFave for an independent informal dispute resolution (IIDR) meeting on November 20, 2015. The meeting concluded on that date.

Holly Kranz and Mary Cahill appeared on behalf of the Minnesota Department of Health (Department). The following individuals also participated in the IIDR on behalf of the Department: Lisa Carey, Gary Nederhoff and Maria King.

Rebecca K. Coffin, Voigt, Klegon & Rode, LLC, appeared on behalf of the Stewartville Care Center (Stewartville or the facility). The following individuals also participated in the IIDR on behalf of the facility: Joseph Owens, Sandi Vrieze and Brad Haugen.

Based on the exhibits and arguments made at the IIDR and for the reasons set forth in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

- (a) The deficiency identified in Tag F-223 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.
- (b) The deficiency identified in Tag F-225 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.
- (c) The deficiency identified in Tag F-226 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.
- (d) The deficiency identified in Tag F-490 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

(e) The deficiency identified in Tag F-493 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

Dated: December 8, 2015

s/James E. LaFave

JAMES E. LAFAVE Administrative Law Judge

NOTICE

Under Minn. Stat. § 144A.10, subdivision 16 (d) (6) (2014), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

This matter arises out of a recertification survey conducted at Stewartville between June 8 and 17, 2015.¹ Pursuant to the IIDR process set forth in Minn. Stat. § 144A.10, subd. 16 (2014), Stewartville challenges the Surveyor's identification of five alleged deficiencies related to the care of its residents.²

Background

The Department issued a Statement of Deficiencies³ in which it asserted that the facility had failed to meet federal regulatory requirements for participation in the Medicare and Medicaid programs in five specific respects:

1. F-Tag⁴ 223: 42 C.F.R. § 483.13(b) and § 483.13(c)(i) provide:

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

³ Ex. E.

¹ Exhibit (Ex.) E at 1.

² The residents' names have been omitted to safeguard their privacy. References to residents are denoted as "R[number]".

⁴ Deficiency findings are noted in a Statement of Deficiencies under numbered "tags." Each tag corresponds to a specific regulatory requirement.

2. F-Tag 225: 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) provide:

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

3. F-Tag 226: 42 C.F.R. § 483.13(c) provides:

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

4. F-Tag 490: 42 C.F.R. § 483.75 provides:

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

5. F-Tag 493: 42 C.F.R. § 483.75(d)(1)-(2) provide:

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for

establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility.

Relying upon the U.S. Department of Health & Human Services' Centers for Medicare and & Medicaid Services' (CMS) Scope and Severity Grid,⁵ the Department assigned F-Tag 223 and F-Tag 225 each a seriousness level of "K."⁶ The Department assigned F-Tag 226, F-Tag 490 and F-Tag 493 each a seriousness level of "F."7

A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.8 A facility is not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.⁹ Such harms result in a rating of "D" or above on the CMS Grid. Upon a finding of a lack of substantial compliance, CMS may require the facility to correct the deficiencies pursuant to a correction plan and impose other sanctions, including decertification from the Medicare and Medicaid programs.¹⁰

The deficiencies alleged by the Surveyor are interrelated and stem from two events that occurred on April 24, 2015. The remaining elements of the deficiencies alleged by the Surveyor revolve around whether Stewartville properly investigated and reported incidents regarding R64, R98 and R99.

The Events of April 24, 2015

a. The incident with R75

LPN-E

is an LPN at Stewartville.¹¹ After dinner on April 24, R75, a 98-yearold woman with Dementia who is hard of hearing,12 started asking questions of LIN-E WERE 13 Were that to raise his voice to respond.14 R75 kept repeating her questions.¹⁵ Mathematica was talking loud but he was not yelling at R75.¹⁶ Others who SPALE LANS

⁵ The CMS Grid is a three-column, four-level matrix that provides 12 alphabetically designated ("A" through "G") categories used by compliance surveyors to rate, for each identified deficiency tag, both the severity of possible or actual harm and the scope of those actually or potentially harmed.

⁶ On the CMS Grid, a "K" designation indicates that a cited deficiency presented "immediate jeopardy to resident health or safety" in a "pattern" scope.

⁷ On the CMS Grid, an "F" designation indicates that a cited deficiency presented "no actual harm with potential for more than minimal harm that is not immediate jeopardy" in a "widespread" scope. ⁸ 42 C.F.R. § 488.400.

⁹ 42 C.F.R. § 488.301.

¹⁰ 42 C.F.R. §§ 488.402, 488.405, 488.408, 488.412, 488.440.

¹¹ Comments of Lessance at IIDR.

¹² Ex. 1; Ex. 2 at 10, pro-¹³ Comments of Jerrienen at IIDR.

¹⁴ Comments of Sand Arts at IIDR.

LPN-0 ¹⁵ Ex. L at 23.

¹⁶ Comments of abudit Adeno, at IIDR.

LPN-3

interaction lasted several minutes.¹⁹ When interviewed by the Surveyor, R75 in - (DON) recounting the incident, asked "Why was he (Here) yelling at me?"20 LPN-E PN-J **Hunter, RN**, overheard the conversation between R75 apd **Margaens**s and reported the incident to provide the Director of Nursing at Stewartville.21 Pon was not available so she left a voice mail describing the matter.²² we report the incident.²³ we called ca discuss the situation.²⁴ It was decided that should go home for the a also stated that we felt the incident was serious enough evening.25 The AON to call it in as a "V.A\incident."²⁶ PN-E

overheard the conversation described it as "yelling"¹⁷ or "yelling and screaming."¹⁸ The

ADN

b. The incident with R65

ADN, LPN-J After the call with the Barbers to talk with the second secon LAN-E As she approached the location where the Output was working, he was being followed R65 is an 87-year-old woman with cognitive by another facility resident, R65. impairment and dementia.27 PN-B

. LPNLE

During the evening of April 24, 2015, R65 was increasingly agitated.28 She was following definition and walking in and out of other residents' rooms.²⁹ A nurse assistant tried to intervene and tried to tell R65 she needed to stav out of other people's rooms.30 At this suggestion, R65 became more agitated.31 went in and LPN-E escorted R65 out of the room.32

LPN·E R65 was arguing with kind was 33 She said "I'm going to hit you! I'm going to kick your assl"34 kereare had left a container of applesauce on the handrail outside of that room.35 R65 picked it up and attempted to swing it at Man Buren. 36 ARC AND A

LPN-E LAN-E In Sugar Merel Last 17 Ex. L at 23. PN-E 18 Ex. L. at 22. and Resident 75 lasted no more than two to five ¹⁹ Ex. 42. (The "interaction between minutes.") Surveyor 20 Comments of 21 Comments of Schultz Berg at IIDR. LPN-5 22 Id. ²³ Id. ²⁴ Ex. L. at 17. LPN-J ²⁵ Id. 26 Comments of Schulinhame at IIDR. 27 Ex. L at 80; Ex. 3 at 1. ²⁸ Ex. L. at 10. ²⁹ /d. ³⁰ Id. ³¹ Id. 32 Jd. LPN-J 33 Id 34 Comments of Comments at IIDR. ³⁵ Ex. L. at 10.

was able to get the container of applesauce out of R65's hand, made sure she was stable with her walker, and asked her to go down the hall.³⁷

As **MUMP** made his way to the medicine cart and R65 returned. **Multiple and R65** returned. **Multiple and R65** offered to give R65 her medications, but she refused.³⁸ R65 grabbed a nearly full pitcher of water off the medicine cart and lifted it as though to hit **Multiple and R65 Multiple and R65**, and grabbed her right forearm, tipping the walker over in the process.⁴⁰ He put his left arm around her waist and was able to get her to put the down.⁴¹

Ministrations then secured R65's left arm and picked up the walker.⁴² While Ministration LPN-E was bending over to pick up the walker, Ministrations saw R65 made a fist as if to hit is LPN-E-Constant.⁴³

primary concern during the incident was to make sure R65 did not hurt herself or others.⁴⁵

Machine left Stewartville immediately after the incident.⁴⁶

R65 was examined at the Mayo Clinic on April 28, 2015.⁴⁷ The charge nurse from Stewartville reported to the Mayo Clinic staff that R65 had some mild swelling on the left thumb web space with a bruise occurring after the incident.⁴⁸ On April 28, 2015, it was observed that R65 had some resolving bruising on her left hand and no further swelling of her left thumb.⁴⁹

The Investigations

Investigation regarding R75 and R65

The staff at Stewartville notified **Constant and Stewartville**, of the incidents with R75 and R65 the evening of April 24, 2015, shortly after the incidents occurred by leaving him a voice mail.⁵⁰ In addition, the staff immediately called **Constant Operation** the Assistant Director of Nursing who determined that **Constant** should be sent home.⁵¹

LPN-E

³⁶ Id.
³⁷ <i>Id</i> . at 11.
³⁸ Id.
³⁹ Id.
⁴⁰ /d.
41 <i>Id.</i>
⁴² <i>Id.</i>
⁴³ <i>Id</i> .
44 Id. LPN-E
⁴⁴ Id. ∠ PN-E ⁴⁵ Comments of Jan Paraments at IIDR.
⁴⁶ Ex. 12. at 3.
⁴⁷ Ex. L. at 80.
⁴⁸ <i>Id.</i>
49 Id. LPN-5
49 <i>Id.</i> LPN-J 50 Comments of Jana Parase at IIDR.
⁵¹ <i>Id</i> .

DON metrieved the voice mail message at approximately 8:30 a.m. on April 25, 2015, and immediately went to the facility.52 On his way to Stewartville, - Po V called the Administrator, Construction, to inform him about the events that had transpired the previous evening.53

DON

When he arrived at Stewartville, Watstanger submitted a report to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC).54 He then began his investigation.55

I ON-E PON LPN-E DON LPN-E Nacionary interviewed With a composition of Marchine gene removed With Contracts from the LPN-E schedule until the investigation was complete.⁵⁷ whethere ordered that upon his return would be required to complete. return, Manager would be required to complete:

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N 2

- Health Care Academy Inservcies; ·· ;·.
- and a transferra A second lines - Right on Target: Respecting Resident Rights;
- Caring for Alzheimer Client,
- Client Behaviors: Assessment and Interventions in the Resident with Dementia: and
- Vulnerable Adult Protection (Abuse Prohibition).58

, LPN-J, ERTHACNA, NA-C DAN Withere then interviewed R75 and R65. He also interviewed witnesses to the incidents, including: Severation of the statements from the severation decision, 60 Sand these, 61 Denisonal States of and States of and States of the states LPNE LPN-5 RN-5 NACT hog

Distary Asde-A. Based upon his investigation, with the Minnesota Board of Nursing and Nursing Administration.65 On April 29, 2015, as required by law,66 he filed an Investigative Report with the OHFC.67 On May 5, 2015, OHFC acknowledged receipt of the report, indicated they had reviewed it and determined no further action by their office was necessary.68

an at IIDR. 52 Comments of ⁵³ Id. PON 54 Ex. 9. 55 Comments of Machineson at IIDR. ⁵⁶ Ex. L. at 10. 57 Id. at 15. PON ⁵⁸ Id. 59 Comments of Beatlehaugeo at IIDR; see Ex. L at 23. 60 See Ex. L. at 26. 61 See Ex. L. at 17. 62 See Ex. L at 18-19. 63 Ex. L. 22. 64 Ex. L. 25. 65 Ex. L. at 21. 66 See 42 C.F.R. § 483.13(c)(4). 67 Ex. L. at 10-12. 68 Ex. 16.

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Investigation regarding R64

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On April 15, 2015, at approximately 4:30 p.m., staff at Stewartville noted R64 sitting in his recliner, attempting to get out of a seated position.⁶⁹ R64's wife was with him and told him to stop.⁷⁰ When R64 continued trying to lift himself out of the recliner, staff observed R64's wife grab the recliner control and hit him on the arm.⁷¹ Staff immediately intervened, separated R64 from his wife and examined R64.⁷² There were no visible injuries noted and R64 denied any pain.⁷³

Social Services and the Administrator were immediately notified.⁷⁴ Stewartville also contacted R64's son to inform him of the incident and R64's son did not voice any concerns.⁷⁵ Stewartville reported the incident to OHFC and Olmsted County on April 16, 2015.⁷⁶ The investigative report was submitted to OHFC the following day,⁷⁷ and OHFC responded to Stewartville informing the facility that OHFC determined no further action was needed at this time.⁷⁸

Investigation regarding R99

On the morning of August 19, 2014, upon entering R99's room, a nursing assistant noted R99's friend (another resident) was lying on the floor and R99 was standing nearby and holding her left arm close to her chest.⁷⁹ Staff assisted R99 to her wheelchair and brought her out to the nurse's desk.⁸⁰ When staff attempted range of motion on R99's left arm, R99 verbally expressed pain.⁸¹ After being assessed by nursing staff, R99 was assessed by the certified nurse practitioner (CNP), who wrote an order to send R99 to the hospital for still further evaluation.⁸² Later that night, Stewartville learned R99 had fractured her left shoulder and was going to be receiving an additional x-ray and CT scan.⁸³

Stewartville investigated the incident involving R99.⁸⁴ Because of R99's Dementia,⁸⁵ she was unable to inform the facility how she injured her arm. However,

⁶⁹ Ex. 18 ⁷⁰ Id. 71 Id. ⁷² Id. ⁷³ Id. ⁷⁴ Id. 75 /d.4/15/15 at 20:32. ⁷⁶ Ex. 19. ⁷⁷ Ex. 20. ⁷⁸ Ex. 21. ⁷⁹ Ex. 22; Ex. 23. ⁸⁰ Id. ⁸¹ Id. ⁸² Id. 83 Ex. 22. ⁸⁴ Ex. 24. ⁸⁵ Ex. 25.

based on the investigation Stewartville determined R99's friend, another resident of Stewartville, fell in R99's room and R99 either attempted to catch her or tried to pick her off the floor which resulted in R99 injuring herself.⁸⁶ Stewartville reported the matter to OHFC on August 20, 2014,⁸⁷ and submitted their investigative report the following day.⁸⁸ OHFC notified Stewartville on August 27, 2014, that they had reviewed the report and determined there would be no further action.⁸⁹

Investigation regarding R98

R98 has been a resident of Stewartville since December 15, 2008, and her diagnoses include Dementia and Alzheimer's.⁹⁰ Because R98 uses aspirin on a daily basis, she is at risk for bruising and staff is directed to observe her for any bruising or hematuria.⁹¹ On the morning of August 10, 2014, staff noticed a bruise R98's left medial forearm, extending along the left thumb and index finger.⁹² Stewartville immediately assessed R98's bruise, applied cold packs and tubi-grip to the area and notified R98's physician.⁹³

Because R98's bruising was of an unknown origin, Stewartville immediately initiated an internal investigation which included interviewing employees and getting staff statements.⁹⁴ Stewartville learned nothing was out of the ordinary for R98 the day before the bruising was noted and was unable to determine the cause of the bruising.⁹⁵ The incident was reported to OHFC.⁹⁶ OHFC notified Stewartville that it determined no further action was needed by the department.⁹⁷

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The Deficiencies

F-Tag 223 – Residents must be free from abuse

Under the quality care regulations, "the resident has the right to be free from verbal ... (or) ... physical ... abuse."⁹⁸ The Surveyor claims Stewartville violated that provision because it failed to ensure an environment free from abuse for R65, R75 and other residents on the floor where **Geomens** worked. It asserts this is a pattern of deficiency that resulted in immediate jeopardy and has affected or has the potential to affect a number of residents. The evidence in the record does not support those claims.

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⁸⁶ *Id.*⁸⁷ Ex. 26.
⁸⁸ Ex. 27.
⁸⁹ Ex. 28.
⁹⁰ Ex. 29.
⁹¹ Ex. 30.
⁹² Ex. 31.
⁹³ Ex. 32.
⁹⁴ Ex. 33; Ex. 34.
⁹⁵ Ex. 35.
⁹⁶ Ex. 36.
⁹⁷ Ex. 38.
⁹⁸ 42 C.F.R. § 483.13(b).

"Abuse" is defined to mean "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.⁹⁹ "Verbal abuse" is defined in pertinent part: "as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . . . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident such as telling a resident that he/she will never be able to see his/her family again."¹⁰⁰

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The Department asserts that R75's statement during the recertification survey, "Why was he yelling at me" and R75's apparent anxiety over the incident coupled with observations that **Wereause** was "yelling and screaming" support the charge of "verbal abuse." In the view of the Administrative Law Judge, the Department overlooks key elements in the definition of "verbal abuse." "Verbal abuse" by definition, includes an element of intent. The comments must be "willful" and they must be "derogatory" or "disparaging." There is nothing in the record to indicate **Wereause** made "willful," "derogatory" or "disparaging" remarks directed at R75. The definition of "verbal abuse" has not been met.

LAN Similarly, there has been no "physical abuse." The Department claims that "physically abused" R65. "Physical abuse" includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.¹⁰¹ The reports indicate R65 had bruising on her left hand. That fact, by itself, does not support a finding of "physical abuse." R65 had a water pitcher in her hand. She was holding it in a threatening manner. A careful review of the record indicates that **Mathematicate** took necessary and proper steps to ensure that R65 did not hurt herself or others. The facts do not support a finding that Stewartville violated 42 C.F.R. § 483.13(b) and § 483.13(c)(i). F-Tag 223 should be set aside.

F-Tag 225 – The facility must fully investigate and report allegations of abuse

Under the quality of care regulations; the facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse ... are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures."¹⁰² The Interpretive Guidelines for § 483.13(c)(2) state that ""immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident."¹⁰³ The Surveyor found that Stewartville failed to thoroughly investigate allegations of abuse and report them to the administrator and state agency immediately. This finding is not supported by the record.

⁹⁹ Ex. F. at 2.

¹⁰⁰ /d.

¹⁰¹ Ex. F. at 2.

¹⁰² 42 C.F.R. § 483.13(c)(2).

¹⁰³ Ex. G. at 3.

During the evening of April 24, 2015, after the incidents involving R65 and R75, the staff at Stewartville immediately telephoned the Director of Nursing. Unable to reach the Director of Nursing, the staff then contacted the Assistant Director of Nursing, who promptly determined that National should be sent home for the evening.

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On the morning of April 25, 2015, the Director of Nursing picked-up his voice mail, notified Stewartville's Administrator, and went to the facility. He submitted a report to OHFC, conducted interviews, requested and collected written statements. All of this occurred within 24 hours of the incidents involving R65 and R75.

The law requires that allegations of abuse must be reported "immediately" to the administrator and other officials.¹⁰⁴ Here, the incidents involving R65 and R75 occurred during the evening of April 24, 2015. Stewartville's Director of Nursing and the Assistant Director of Nursing were contacted that night. The Stewartville Administrator and the OHFC were notified the next morning. In addition, Stewartville notified the Minnesota Board of Nursing and the Nursing Administration. Finally, Stewartville timely filed its Investigation Report with OHFC. Similarly, with regard to the matters involving R64, R98 and R99, each incident was investigated and properly reported within 24 hours.

The facts do not support a finding that Stewartville violated 42 C.F.R. § 483.13(c)(2). F-Tag 225 should be set aside.

F-Tag 226 – The facility must implement the policies to prohibit abuse

Under the quality care regulations, "the facility must develop and implement written policies and procedures that prohibit, mistreatment, neglect, and abuse of residents^{*105} The Surveyor determined this requirement was not met because the facility failed to operationalize its abuse prohibition policies related to timely reporting, thorough investigation of incidents, training of facility staff and protection of residents. It asserts this deficiency had the potential to affect all residents. The Administrative Law Judge disagrees.

Stewartville developed and implemented policies and procedures to prevent resident abuse and neglect.¹⁰⁶ Stewartville requires its employees to look for signs of abuse and neglect¹⁰⁷ and immediately report and investigate incidents or accidents involving residents.¹⁰⁸ During the investigation, the accused individual will not be employed.¹⁰⁹ The facts demonstrate Stewartville followed its policies and procedures. In the cases of R64 and R75, the alleged verbal and physical abuse by was removed from the schedule during the investigation. Reports were filed with OHFC, the Minnesota

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¹⁰⁴ 42 C.F.R. § 483.13(c)(2).

¹⁰⁵ 42 C.F.R. § 483.13(c).

¹⁰⁶ Ex. 39 (Vulnerable Adult Policies and Procedures).

¹⁰⁷ Id. at Recognizing Signs and Symptoms of Abuse/Neglect.

¹⁰⁸ /d.

¹⁰⁹ Id.

Board of Nursing and the Nursing Administration. In addition, Stewartville also followed its policies and procedures and immediately investigated and reported the incidents with R65, R64, R98 and R99.

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The facts do not support a finding Stewartville violated 42 C.F.R. § 483.13(c). F-Tag 226 should be set aside.

F-Tag 490- Effective Administration

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The Department claims Stewartville violated 42 C.F.R. § 483.75 because Stewartville's administrator failed to ensure the abuse prohibition policies were carried out and that there was inadequate oversight of services to ensure residents were free from abuse. The Department asserts this deficiency has the potential to affect all resident. The Administrative law Judge disagrees.

The Department cites the deficiencies asserted in F-Tag 223, F-Tag 225 and F-Tag 226 as the basis for this deficiency.¹¹⁰ As discussed above, the evidence in the record does not support the deficiencies alleged in F-Tag 223, F-Tag 225 and F-Tag 226. Further, Stewartville has a Quality Assurance and Assessment Committee (QAAC) which meets quarterly to review issues related to resident care.¹¹¹ The QAAC reviews matters involving resident safety, vulnerable adult reports, incidents and grievances.¹¹² Stewartville also meets monthly with its Medical Director to review items related to resident care.¹¹³

The record demonstrates that Stewartville substantially complied with 42 C.F.R. § 483.75. F-Tag 490 should be set aside.

F-Tag 493 – Governing Body

Under the quality of care regulations, the facility "must have a governing body . . . that is legally responsible for establishing and implementing policies."¹¹⁴ The regulations further require that the governing body appoint an administrator who is "responsible for the management of the facility."¹¹⁵ The Department claims Stewartville violated those provisions because Stewartville's governing body did not ensure abuse policies and procedures were carried out by the administrator and that Stewartville's governing body did not perform adequate oversight of services to ensure resident were free from abuse. The Administrative Law Judge disagrees.

¹¹⁴ 42 C.F.R. § 483.75(d)(1).

¹¹⁰ Ex. E at 80-82.

¹¹¹ See Ex. 40 (Quality Assurance and Assessment Committee Minutes).

¹¹² Id.

¹¹³ Ex. 41.

¹¹⁵ Id.

The Department supports this deficiency by again citing to the record underlying F-Tag 223, F-Tag 225 and F-Tag 226. As the record does not support those tags, there is no support for this tag. F-tag 493 should be set aside.

Conclusion

The incident between **WRACE** and R75 and the incident between **WRACE** and R65 form the basis for the Surveyor's findings of abuse. Those findings of abuse, set forth in F-Tag 223, provide the foundation for the remaining deficiencies found by the Surveyor. F-Tag 223 is specifically cited as one of the grounds for F-Tag 490¹¹⁶ and for F-Tag 493.¹¹⁷ In this context, it is important to note that the Survey Team did not interview **MRACE** as part of the recertification survey or the extended survey.¹¹⁸ The Survey Team did not even ask to interview **MRACE**.¹¹⁹ In the view of the Administrative Law Judge, that omission undermined the reliability of the Surveyor's inquiries and conclusions regarding F-Tag 223 and the findings in the other deficiencies.

The Administrative Law Judge respectfully recommends that the Commissioner set aside F-Tag 223, F-Tag 225, F-Tag 226, F-Tag 490 and F-Tag 493.

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116 See Ex. E at 80. 117 See Ex. E. at 83.

¹¹⁸ Comments by Lisa Carey in response to questions from the facility at IIDR. The Survey Team observed Me Gwens at Stewartville on June 15, 2015. See Stewartville Care Center Survey Exit June 17, 2015 at p. 6 (" LPN-E WWW (WWW) was observed on 6/19/15 at 3:45 p.m. to be conducting a medication pass on a unit in the lower level of the facility"). Presumably, he was available for questioning.

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[62162/1]

Surveyor



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

December 18, 2015

Rebecca K. Coffin Voigt, Rode and Boxeth, LLC 2550 University Avenue West Suite 190 South St. Paul, MN 55114

RE: Docket OAH 60-0900-32874

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Stewartville Care Center in Stewartville, MN, regarding five federal deficiencies issued as a result of a recertification survey, exit date June 17, 2015. The IIDR was held before Administrative Law Judge James E. LaFave. The Department received Judge LaFave's recommended decision the afternoon of December 8, 2015.

Decision

After careful review of Judge LaFave's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with rescinding tags F223, F225 or F226, and uphold them as written. F223 and F225 were written at a scope and severity of Level K, and F226 was issued at a scope and severity of F. I concur with rescinding tags F490 and F493.

Rationale

During Stage 1 of the survey, the Abuse Task was triggered. When a task is triggered, a surveyor follows a specific pathway – an established and computer directed set of investigative protocols, to investigate whether there was a deficient practice in the task area. The tags issued in this survey are a result of the extended survey that was conducted as a result of the triggering of the Abuse Task.

It is not disputed that the incidents in this IIDR occurred. What is disputed is the conclusion of Stewartville's internal investigation of the incidents, the incomplete manner in which the internal investigations were conducted, the sequence and timing of reporting the incidents to the State Agency (Office of Health Facility Complaints - OHFC), and the accuracy of the

Ms. Rebecca K. Coffin Page 2 December 18, 2015

information on the reports to the OHFC when compared to the information in the facility's incident files.

Tag F223 requires a resident has *the right* to be free from *verbal*, sexual, *physical and mental abuse*, corporal punishment, and involuntary seclusion. The intent of the regulation is that residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Interpretive Guidelines include a definition of abuse: "abuse" means the willful infliction of injury, unreasonable confinement, *intimidation*, or punishment with resulting physical harm, pain or *mental anguish*." (42 CFR §488.301) The Interpretive Guidelines, further define types of abuse: verbal abuse, sexual abuse, physical abuse, mental abuse and involuntary seclusion. "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse *include, but are not limited to*: threats of harm; *saying things to frighten a resident*, such as telling a resident that he/she will never be able to see his/her family again. "Mental abuse" *includes, but is not limited to* humiliation, harassment, and threats of punishment or deprivation.

The surveyor found two facility incident reports involving R65 and R75 with allegations of physical and verbal abuse involving LPN-E. Both incidents occurred on April 24, 2015.

R65 was a cognitively impaired resident, who exhibited short and long term memory loss. R65 exhibited behavioral symptoms including paranoia and at times was physically resistive with cares. R65 could usually make her needs known and could walk independently with a wheeled walker.

R75 was cognitively impaired with short and long term memory loss. R75 did not have a history of abusing others, had adequate hearing at a normal level of conversation and was able to express her needs verbally.

The facility contends that LPN-E did not verbally abuse R75, rather he was speaking loudly so R75 could hear him. The facility noted it suspended LPN-E pending further investigation of R65 and reported the incident to the OHFC. After conducting its internal investigation, Stewartville concluded LPN-E was trying to keep R65 safe and prevent her from harming herself or others. They concluded that LPN-E did not abuse R65 or intend to harm her in any way.

The Centers for Medicare and Medicaid (CMS) require surveyors to follow Interpretive Guidelines when determining whether a deficient practice exits. When looking at allegations of potential abuse to residents, all possible types of abuse must be considered. While the term "willful infliction of" is used in the definition of abuse, it is not further defined in the Interpretive Guidelines at F223. "Willful" is defined in the State Operations Manual in Appendix Ms. Rebecca K. Coffin Page 3 December 18, 2015

PP, Interpretive Guidelines for an abuse and supervision tag as: "means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish." The New World Dictionary of the American Language defines "willful" as: "1. said or done deliberately or 2. Following one's own will unreasoningly; obstinate; stubborn." Raising one's voice very loudly, or yelling at a resident to be heard, seeing the resident is further distressed as a result of that action and yet continuing the action is a willful act, it is an action committed unreasoningly. Moreover, there were several staff onsite (RN-H, LPN-J, NA-E, NA-C) at the time who overheard the loud interaction between LPN-E and R75. These staff were concerned enough by the interaction to leave areas they were working in such as the dining room, hallway, and other resident rooms, to check out what was happening. These other staff who were familiar with LPN-E and R75, did not consider the interaction to be "normal", that is, that LPN-E was speaking loudly in an attempt to allow R75 to hear him. RN-H was concerned enough by this observation that she immediately called the assistant director of nursing to report she was concerned about LPN-E's "mental state." The other staff were concerned enough about the incident to file facility Complaint/Concern Forms Regarding Employee, one included: "Upon returning from bringing residents from supper, co-worker [NA-E] and I heard a lot of commotion/screaming. We noticed that the nurse [LPN-E] was yelling and screaming at [R75]. We tried to take her to her room. She [R75] asked [LPN-E] another question and he started yelling at her again. That's when we removed her [R75] from the situation around 7:40. I went to go ask nurse [LPN-J] a question and noticed [R65] standing by med cart arguing with [LPN-E]. She attempted to grab water pitcher and he grabbed her from behind like choke hold. I attempted to go over but [LPN-J] went over and intervened. I tried to calm resident down afterwards but she was too worked up."

The nursing assistant who documented the Complaint/Concern report noted above was listed as a witness in the investigative report the facility sent into the OHFC as required; however, that report did not provide this firsthand witnesses' account as stated above. Instead the report to OHFC included: "During routine MDH survey it was brought to this writer's attention that on 4-24-15, staff [LPN-E] was yelling at [R75]. This incident was initially reported regarding another demented resident. During this incident [R75] was also agitated and following the nurse and not responding to redirection. [LPN-E] did yell at resident due to his frustration with [R65] and her continued agitation. This writer initially combined both of these actions by [LPN-E] into one investigation and I am now reporting this particular situation as a separate incident. [R75] has not suffered any negative effects from this situation and continues to wander the facility in her w/c as usual."

The other nursing assistant who had witnessed this incident, and who was referenced in the Complaint/Concern report, was not interviewed by the facility during the investigation of the incident. According to the CMS 2567, Statement of Deficiencies, R75 conversed with survey staff during the survey and was able to do so without hearing difficulty. Additionally, the

Ms. Rebecca K. Coffin Page 4 December 18, 2015

facility's care plan indicated that although R75 had some hearing loss, her hearing was adequate at a normal level of conversation.

The initial incident report related to R65, submitted by the facility on 4/25/15 omitted the above interaction between LPN-E and R75 entirely. In addition, there was no reference to eyewitness NA-C's description of R65 having been placed in a "choke hold". The initial incident report also indicated R65 experienced no injuries, however facility progress notes indicated R65 had swelling and pain in her left thumb and had received pain medications for the discomfort. R65 was examined by her nurse practitioner for an "evaluation after physical assault" on 4/28/15 when bruising was noted to R65's left thumb web space.

LPN-E was observed in the facility on 6/9/15 during a medication pass. This observation occurred three days prior to the survey team identifying the immediate jeopardy on 6/12/15. This statement is included in the CMS 2567 to verify LPN-E was observed at the time of survey and had continued to remain a direct patient caregiver. LPN-E was not interviewed after the IJ was called because he had been removed from the facility's work schedule after 6/11/15. The facility was in an immediate jeopardy (IJ) and working to abate the IJ by conducting its own internal investigation, which involved LPN-E. The MDH could not interfere with that investigation. In addition, written statements by LPN-E about the incidents provided to the survey team acknowledge LPN-E was frustrated at the time the incidents occurred and that he could have handled the situation better, confirming that his loud volume was not appropriate and the resident responded negatively. In an undated document provided by LPN-E to the facility as part of the initial investigation into R65's incident LPN-E stated, "I know confronting anyone in her [R65's] condition is not the way to handle these situations but sometimes cercomstances [sic] prevent the ideal situation." The follow up investigation report submitted to OHFC by the DON on 4/29/15 indicated LPN-E "admits he could have handled the situation differently, and understands that his response was inappropriate."

This deficiency is properly cited at a Level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

Tag F225 requires that the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported *immediately* to the administrator of the facility *and* to other officials in accordance with state law through established procedures (including to the state survey and certification agency), and the facility must have evidence that all alleged violations are *thoroughly* investigated, and *must prevent further potential abuse* while the investigation is in progress.

The facility's investigation into R65's incident of alleged physical abuse included written statements and interviews with some, but *not all*, staff present at the time of the incident. The

Ms. Rebecca K. Coffin Page 5 December 18, 2015

investigation included an interview with R65, who was unable to recall the details of the incident. This investigation was submitted to OHFC on 4/29/15. The investigation minimized the severity of the situation by indicating R65 had not experienced any injuries as a result, lacked information concerning an allegation of mistreatment towards R75 on the same evening, and lacked an eyewitness description from NA-C describing R65 being put in a choke hold. The investigative report indicated LPN-E had not had any prior allegations of abuse, however LPN-E had a verbal allegation of abuse that very same evening just prior to R65's incident. No interviews were conducted with other residents LPN-E cared for, to determine the extent of his misconduct or if other residents had been affected in the past or if there was indeed a history of inappropriate behavior on LPN-E's part. R75's incident of alleged mistreatment was not investigated by the facility until it was identified by the survey team.

R98 exhibited bruising and signs of injury to her left forearm on 8/10/14. R98 was physically dependent on staff in all aspects of her care, was cognitively impaired and required a mechanical lift for transfers. An x-ray taken after the injury was identified revealed a comminuted fracture of the distal radius. The facility investigative report submitted to OHFC on 8/15/14 included interviews with the resident's roommate, and staff who had cared for R98 for the previous 24 hours. The investigative report concluded: "Reasonable explanation of comprehensive investigation results indicates that resident's incident was a result of therapeutic conduct during the normal course of care." The investigative report lacked interviews with other staff members beyond the immediate 24 hour window, and assumed the care plan was followed without a review of all of the circumstances present. The investigative report also lacked a review of the medical record, to identify whether R98 had signs of pain prior to the incident or any other details in an attempt to identify a specific timeframe for when the injury had occurred.

R99 sustained a fractured left shoulder on 8/19/14. R99 was a cognitively impaired individual who was independent in ambulation with the use of a walker, and was determined by the facility not to be a reliable reporter of maltreatment. R99 did not have a history of abuse towards others. R99 had been found by facility staff in her room holding her left shoulder. Another resident, a friend of R99's was found on the floor lying alongside her. The facility's investigative report, submitted to OHFC on 9/21/14 indicated the facility interviewed R99's friend, who also was cognitively impaired and stated R99 "fell in the yard the other day." The investigative report indicated other residents and family in the area were interviewed and did not notice anything out of the ordinary. The investigative report does not include interviews with facility staff that had contact with R99 at the time of the incident or prior to the event, and concludes that "Comprehensive investigation results indicate that resident was injured in the course of attempting to help her friend." There is no evidence to suggest there was a review of circumstances surrounding the incident, including a review of the immediate environment to further identify how R99 may have fallen or injured herself.

Ms. Rebecca K. Coffin Page 6 December 18, 2015

There is no evidence in the facility records that these incidents were thoroughly investigated. Stewartville Care Center's policies, entitled Abuse and/or Neglect Investigation indicate investigations should include interviews with other residents in which the employee provides care or services, review of all circumstances surrounding the incident, interviews with all staff having contact with the resident during the period of the alleged incident, and interviews with the resident's roommate, family member and visitors and a review of the resident's medical record.

This deficiency is properly cited at a level K: the scope is a pattern where more than a limited number of residents are/could be affected, and the severity is an immediate jeopardy to resident health or safety.

F226 requires that the facility must develop and *implement* written policies and procedures that *prohibit mistreatment*, neglect, and *abuse* of residents and misappropriation of resident property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences of resident *abuse*, neglect, *mistreatment* and misappropriation of property.

R65's investigative report which was submitted to OHFC on 4/29/15, indicated LPN-E would have follow up with the facility social worker related to his approach in caring for cognitively impaired residents with behaviors. There is no evidence this follow up took place to ensure LPN-E's conduct with R65 remained appropriate. The facility's policy, entitled Preventing Resident Abuse included an intervention of including "scheduled in-service training programs designed to teach staff how to better understand the resident's abusive actions." There was no evidence this training was provided to LPN-E, or to newly hired staff whose employment files had been reviewed during the survey. LPN-E did not receive specific training related to care of residents with behaviors until 4/25/15 although he had been employed at the facility since 1/14.

F226 was cited as an "independent but associated deficiency" citation. The MDH is expected to cite deficient practices at all appropriate regulatory requirements. F226 was cited for the facility's failure to *fully operationalize* its abuse/neglect policy with respect to the immediate reporting of abuse, neglect, mistreatment and misappropriation of property, failure to educate staff related to management of residents with behaviors, failure to fully investigate incidents of alleged abuse and failure to protect residents after alleged incidents of abuse occurred. This was evidenced by the failure to immediately *report* the allegation of mistreatment towards R75 to OHFC and complete a *thorough* investigation in a timely manner. Additionally, the facility failed to remove LPN-E from direct patient care after this incident occurred. This constituted a failure to *protect* residents from further abuse, and resulted in a second allegation the same evening with R65. In R65's situation, the facility failed to *conduct a thorough investigation*, including interviewing all potential witnesses to the events and other residents to determine

Ms. Rebecca K. Coffin Page 7 December 18, 2015

the extent of LPN-E's misconduct. Subsequent investigative reports to OHFC lacked pertinent, critical details related to eyewitness descriptions of the incidents and injury to the resident. R98 and R99 sustained fractures that were not *thoroughly investigated* as discussed at F225 and directed by the facility's policies. Lastly, Stewartville Care Center failed to ensure LPN-E and other direct caregivers employed at the facility received the necessary *training* related to management of behaviors, in an attempt to *prevent* abuse from occurring within the facility. Evaluation of the facts and the staff's actions related to these incidents represents a systemic failure on the part of the facility to implement their policies at multiple levels.

The deficiency is properly cited as an independent but associated deficiency at Level F: a widespread practice with no actual harm, and potential for more than minimal harm that is not immediate jeopardy.

F490 and F493 were cited as "independent but associated deficiencies." There were undated policies in place for all of the components of tags F223, F225 and F226. While the internal investigations were not thorough and the information submitted to OHFC was not comprehensive and reflective of the Information the facility had in its file, the administrator and governing body were receiving notification of alleged incidents and investigative reports that appeared to be timely and complete. The expectation that the administrator and governing body would have knowledge, prior to this survey, of the inadequacy of the investigations, and the timeliness and sequencing of reporting and investigating, is not supported by the record. These deficiencies should be rescinded.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H. Commissioner P.O. Box 64975 St. Paul, MN 55164-0975

cc: Judge James LaFave Jan M. Suzuki, CMS Region V Cheryl Hennen Darcy Miner Holly Kranz Monica Larson



Protecting, Maintaining and Improving the Health of Minnesotans

<u>IIDR</u>

Independent Informal Dispute Requested

This facility has requested an Independent Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Stewartville Care Center 00429	6/17/2015	F223 = K F225 = K F226 = F F490 = F F493 = F

VOIGT, RODÈ & BOXETH, LLC

ATTORNEYS AT LAW

2550 UNIVERSITY AVENUE WEST SUITE 190 SOUTH SAINT PAUL, MINNESOTA 55114

Susan M. Voigt Robert F. Rodè April J. Boxeth Rebecca K. Coffin Kelsey S. Nelson George J. Berens TELEPHONE651-209-6161FACSIMILE651-209-6160

July 15, 2015

21463-004

Minnesota Department of Health Nursing Home Informal Dispute Process Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

RECEIVEI JUL 1 6 2007 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION

Re: Independent Informal Dispute Resolution for Stewartville Care Center for Survey Exit Date June 17, 2015

Dear Health Department Reviewer:

Please be advised this firm represents Stewartville Care Center ("Stewartville") with respect to the deficiencies issued during its extended survey completed on June 17, 2015. Pursuant to 42 CFR § 488.331, Stewartville requests an independent informal dispute resolution ("IIDR"). Stewartville disputes the deficiencies cited at F223, scope and severity level "K," F225, scope and severity level "K," F226, scope and severity level "F," F490, scope and severity level "F," F493, scope and severity level "F," and the corresponding state licensing correction orders issued regarding the same. Stewartville requests the IIDR process pursuant to Minnesota Statutes § 144A.10, subd. 16.

Stewartville disputes F223, F225 and F226 because it did report and follow up on allegations of mistreatment, conducted internal investigations, interviewed and provided education to staff, and notified the appropriate parties of the incidents. Stewartville followed its abuse prohibition policies in reviewing and investigating these incidents.

Stewartville disputes F490 and F493 because it does have an Administrator and governing body who provide oversight of cares delivered by the facility, facility practices, and the development and implementation of facility policies, including abuse prohibition.

The findings cited on CMS Form 2567 are incorrect and do not support the deficiencies issued F223, F225, F226, F490 and F493. Stewartville will submit additional information to

support its appeal through the IIDR process. We would like a face-to-face meeting through the Office of Administrative Hearings. Thank you for your consideration.

Sincerely,

Rebecca Offin

Rebecca K. Coffin

RKC/ams

cc: Mr. Gene Gustason

DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: LEHX
1. MEDICARE/MEDICAID PROVIDE (L1) 245349 2.STATE VENDOR OR MEDICAID N (L2) 334740100	ER NO.	3. NAME AND AI (L3) STEWARTY (L4) 120 FOURT (L5) STEWARTY	DDRESS OF FAC VILLE CARE H STREET N	CILITY CENTER		Facility ID: 00429 4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF ((L9) 6. DATE OF SURVEY 08/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP 1/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 04/30
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	N 73 (L18) 73 (L17)	Complianc 1. A B. Not in Con	nce With equirements ee Based On: .cceptable POC npliance with Prog	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
	15 ()	Requirem	ents and/or Appli	ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF 73 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (1.43)		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM See Attached Remarks	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lisa Carey (Krebs), HFE 1	NE II	0	8/25/2015	(L19) k	Ka <u>mala Fiske-Downing,</u> I	Enforcement Specialist 08/26/2015 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	L OFFICE OR SINGLE S	
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	ł CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 09/01/1986	BEGINNINC		ENDING DA		<u>VOLUNTARY</u> <u>0(</u> 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:	(1.44)		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L44)			00-20170
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245349

August 26, 2015

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, Minnesota 55976

Dear Mr. Gustason:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 27, 2015 the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 73 skilled nursing facility beds located in rooms.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Stewartville Care Center August 26, 2015 Page 2

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 25, 2015

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, Minnesota 55976

RE: Project Number S5349025

Dear Mr. Gustason:

On July 7, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective July 12, 2015. (42 CFR 488.422)

In addition, this Department recommended the following remedy to the CMS Region V Office for imposition:

• Per instance civil money penalty for the deficiencies cited at F323, F225, and F226. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on June 17, 2015. At the time of the extended survey, conditions in the facility constituted Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health or safety. The survey found the most serious deficiencies to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 27, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on June 17, 2015, as of July 27, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 27, 2015.

In addition, this Department recommended the following action related to the remedy in our letter of of

Stewartville Care Center August 18, 2015 Page 2

July 7, 2015:

• Per instance civil money penalty for the deficiencies cited at F323, F225, and F226 remain in effect. (42 CFR 488.430 through 488.444).

As we notified you in our letter of July 7, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 17, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	entification Number A. Building		(Y3) Date of Revisit 8/11/2015			
Name of Facility		Street Address, City, State, Zip Code				
STEWARTVILLE CARE CENTER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction				Correction					Correction
ID Prefix	F0166		Completed 07/16/2015	ID Prefix	F0223		Completed 6/17/2015		ID Prefix	F0225		Completed 06/17/2015
	483.10(f)(2)		_		483.13(b), 483.13(c)(1)(i)				483.13(c)(1)	(ii)-(iii), (c)(2) -
LSC			-	LSC					LSC			
			Correction			C	Correction					Correction
ID Prefix	E0226		Completed 06/17/2015	ID Brofiv	E0047	C	Completed 7/27/2015			50050		Completed
	483.13(c)		00/17/2015	ID Prefix	483.15(e)(2)	U	1/21/2015		ID Prefix			07/27/2015
LSC			-	LSC	403.15(0)(2)				LSC	483.15(g)(1)		
					2001.0110000000000000000000000000000000			<u> </u>				
			Correction Completed				Correction Completed					Correction Completed
ID Prefix	F0279		07/17/2015	ID Prefix	F0280		7/17/2015		ID Prefix	F0309		07/16/2015
Reg. #	483.20(d), 4	B3.20(k)(1)			483.20(d)(3), 483.			5		483.25		
				LSC					LSC	Ferley and a second sec		
			Correction			С	orrection					Correction
ID Prefix	F0323		Completed 07/17/2015	ID Prefix	F0325		Completed 7/17/2015		ID Prefix	F0431		Completed 07/17/2015
	483.25(h)				483.25(i)	·				483.60(b), (d	d). (e)	
LSC				LSC					LSC		-,, (-)	
			Correction			0						Ormertien
			Completed				orrection Completed					Correction Completed
ID Prefix			07/17/2015	ID Prefix		0	7/16/2015		ID Prefix	F0490		07/16/2015
Reg. # LSC	483.65			Reg. #	483.70(h)				Reg. # LSC	483.75		_
.												
Reviewed E	Ву	Reviewed	Ву	Date:	Signature o	of Surve	eyor:			· .	Date:	
State Agen	су	GPN/kf	d	08/25/20	15		3	34985	5		08/	11/2015
Reviewed E CMS RO	Зу	Reviewed	Ву	Date:	Signature o	of Surve	eyor:				Date:	
Form CMS -	2567B (9-92)	n an an an an an Albert a Lind yn yn yn ar yn ar		Page 1 of 2					Event ID:	LEHX12	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/11/2015
Name of Facility		Street Address, City, State, Zip Code	
STEWARTVILLE CARE CENTER		120 FOURTH STREET NORTH STEWARTVILLE, MN 55976	EAST

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date ((4) Item		(Y5) Date	(Y4)	Item (`	Y5) Date
ID Prefix	F0493	Correction Completed 07/16/2015	ID Prefix	F0497	Correction Completed 07/27/2015			
Reg. # LSC	483.75(d)(1)-(2)		Reg. # LSC	483.75(e)(8)				
						+		
Reviewed	By Boy	iewed By	Date:	Signature	of Surveyor:			Date:
State Ager		PN	8-15-	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	349	85		08/11/2015
Reviewed		-1/ riewed By	Date:		of Surveyor:	0.)		Date:
CMS RO	-							
Followup	to Survey Comple			Check for any	Uncorrected Def	icienc MS-25	ies. Was a Summary of 67) Sent to the Facility?	YES NO
	6/17/201	5		Uncorrected				YES NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245349	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 7/21/2015			
Name of Facility		Street Address, City, State, Zip Code				
STEWARTVILLE CARE CENTER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	()	(5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 07/15/2015	ID Prefix		Correction Completed 06/15/2015	ID Prefix		Correction Completed
0	NFPA 101 K0018			NFPA 101 K0025		Reg. # LSC		
Reg. #		Correction Completed	Reg. #		Correction Completed	Dog #		Correction Completed
Reg. #		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #		Correction Completed			Correction Completed			Correction Completed
Reg. #		Correction Completed	Reg. #			Dog #		
Reviewed E		Ву	Date:	Signature of S	Surveyor:		Date:	
State Agen Reviewed E CMS RO	cy 3y — Reviewed	Ву	Date:	Signature of S	Surveyor:		Date:	
Followup t	o Survey Completed on 6/9/2015	:		Check for any Un Uncorrected De		ciencies. Was a IS-2567) Sent to		NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 25, 2015

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, Minnesota 55976

Re: Reinspection Results - Project Number S5349025

Dear Mr. Gustason:

On August 11, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 11, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00429	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/11/2015	
Name	e of Facility	•	Street Address, City, State, Zip Code	•	
ST	EWARTVILLE CARE CENTER		120 FOURTH STREET NORTH STEWARTVILLE. MN 55976	EAST	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix	20130	Correction Completed 07/16/2015		20285	Correction Completed 07/27/2015	ID Prefix	20302	Correction Completed 07/27/2015
Reg. # LSC	MN Rule 4658.00		-	IN Rule 4658.0100		Reg. # LSC	MN State Statute 14	
ID Prefix Reg. # LSC	MN Rule 4658.04		ID Prefix _ Reg. # N	20570 IN Rule 4658.0405	-	0	_20830 MN Rule 4658.0520 \$	-
0	20965 MN Rule 4658.06	-	ID Prefix _ Reg. # N	21375 IN Rule 4658.0800	-	Reg. #	21426 MN St. Statute 144A	Correction Completed 08/11/2015 .04 Sul
ID Prefix Reg. # LSC	MN Rule 4658.10	Correction Completed 07/27/2015 005 Subp.	ID Prefix Reg. # N	21610 IN Rule 4658.1340			21685 MN Rule 4658.1415 \$	Correction Completed 08/11/2015 Subp.
ID Prefix Reg. # LSC	21880 MN St. Statute 1	Correction Completed 07/16/2015 44.651 Sul	ID Prefix	21980 IN St. Statute 626	Correction Completed 06/17/2015	ID Prefix Reg. # LSC	21995 MN St. Statute 626.5	Correction Completed 06/17/2015 57 Sul
	·	viewed By	Date:	Signature of	•	4985	Date:	
State Agen Reviewed I CMS RO	· 0.	NP/kfd viewed By	08/25/201 Date:	Signature of		703	Date:	08/11/2015
STATE FOF	RM: REVISIT REPO	ORT (5/99)		Page 1 of 2			Event ID: LEHX12	2

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00429	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/11/2015			
Name	e of Facility		Street Address, City, State, Zip Code				
ST	EWARTVILLE CARE CENTER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4) Item	(Y5)	Date
			Correction								
ID Prefix	22000		Completed 06/17/2015								
Reg. # LSC	MN St. Statu	te 626.557	' Su								
				-							
										1	
Reviewed I	Ву	Reviewed	Ву	Da	te:	Signature	of Surv	eyor:		Date:	
State Agen	су										
Reviewed I	Ву	Reviewed	Ву	Da	te:	Signature	of Surv	eyor:		Date:	
CMS RO											
Followup t	to Survey Cor	-	1:			Check for any	Uncorr	ected Defic	iencies. Was a Summary of		
		/2015						encies (CM	S-2567) Sent to the Facility?	YES	NO
STATE FOF	RM: REVISIT F	REPORT (5	j/99)			Page 2 of 2	2		Event ID: I	LEHX12	

DEPARTMENT OF HEALI						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: LEHX
1. MEDICARE/MEDICAID PROVID (L1) 245349		3. NAME AND AI	DDRESS OF FAC	CILITY		Facility ID: 00429 4. TYPE OF ACTION: 2 (L8)
(L1) 245349 2.STATE VENDOR OR MEDICAID (L2) 334740100	NO.	(L4) 120 FOURT (L5) STEWARTY	H STREET N			1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 06 / 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	17/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 04/30
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With			The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	73 (L18)	-	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	73 (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli		* Code: B	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 73	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gail Sorensen, HFE NE I	Ί	(07/17/2015	(L19) F	Ka <u>mala Fiske-Downing, I</u>	Enforcement Specialist 07/30/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	IFNT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING		ENDING DAT		<u>VOLUNTARY</u> <u>0</u>	
09/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	(L44)			07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(2)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE	Posted 07/31/2015 Co	
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted July 7, 2015

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, Minnesota 55976

RE: Project Number S5349025

Dear Mr. Gustason:

On June 17, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 16, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 gary.nederhoff@state.mn.us Telephone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective July 12, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per instance civil money penalty for the deficiencies cited at F323, F225, and F226. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 17, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 17, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	Minnesota Departm 10, 11, 12, 13, 15, 1 resulted in an Imma and F225 related to comprehensively as allegations of abuse administrator and s implement interven free from abuse wh potential for harm of notified of the IJ on The IJ was remove p.m., however non- scope and severity that is not immedia An extended survey Minnesota Departm 15, 16 & 17, 2015. The facility's plan o as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electror be used as verificat Upon receipt of an on-site revisit of you validate that substa	y was conducted by the nent of Health on June 12, 13, f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will					
F 166 SS=E	•	TO PROMPT EFFORTS TO NCES	F 1	66			7/16/15
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed						07/17/2015

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.

PRINTED: 07/17/2015

	-	AND HUMAN SERVICES				APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245349	B. WING		06/	17/2015	
NAME OF I	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 166	facility to resolve gr have, including the of other residents. This REQUIREMEN by: Based on observar review, the facility f grievances were re residents (R53, R4 grievance to the fac Findings include: During an interview p.m. R53 reported long. R53 stated, "S night. I've told all the I've asked if they ca nothing happens. T doesn't work. She don't do anything for Documentation in F 5/3/15, at 1:39 a.m "can't sleep with he from 5/3/15 at 1:46 on ss [social servic that incident." On S note entry included was doing over by	right to prompt efforts by the rievances the resident may se with respect to the behavior NT is not met as evidenced tion, interview and document ailed to ensure resident solved promptly for 4 of 4 6, R7 & R66) who expressed a cility staff.	F 1	 66 Stewartville Care Center staff in the residents; right to autonom choice and protects and promoresidents; legal rights as well a right to privacy and a dignified of The staff encourage the resider concerns about care and/or ser respect their right to have promattention to help resolve grieval including concerns about the boother residents. The policies and procedures for responding to residents; grieval reviewed and found appropriate receiving a complaint/grievance facility seeks a resolution in a timanner and keeps the resident appropriately apprised of the pritoward resolution. The resident are asked about care concerns quarterly interdisciplinary care conferences. The grievance reporting proceder explained to the resident at the 	y and otes the is their existence. Its to voice vices and pt staff nces ehavior of ances were e. After e, the mely ogress s/families during the		
	animal to hold so s R53's quarterly Min	he wouldn't holler" nimum Data Set (MDS) dated ntact cognition with no		admission and grievance forms provided in the admission pack Grievance forms are also availa nursing desks and first floor rec area. Concerns expressed oral	are ets. able at the ception		

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE			0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				()	PLETED
		245349	B. WING _	VING STREET ADDRESS, CITY, STATE, ZIP CODE		06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 166	Continued From pa	age 2	F 16	66			
	a.m. R46 state, "at hollers. It keeps ma An entry in R46's n at 4:43 a.m. include during the night be her awake which u that makes her ner R46's annual Minin 4/29/15, indicated t cognition with no b issues. During an interview p.m. R7 stated, "we door that yells befo During an interview p.m. R7 said she h of nursing (DON) a night, so the DON I room, "but she is n R7's annual MDS of had intact cognition communication iss During an interview p.m. R66 said, "It is yelling for help a lo R66's quarterly MD	nedical record dated 5/16/15, ed, "States she can't sleep cause her roommate keeps sually sets off the alarm and vous Message left for SS." num Data Set (MDS) dated the resident had intact ehavioral or communication with R7 on 6/8/15, at 6:36 e have a person (R30) next ore she goes to bed." with R7 on 6/11/15, at 3:40 ad complained to the director about the noise R30 made at had moved R30 to another row in the room next to me." dated 3/31/15, identified R7 n with R66 on 6/8/15, at 06:44 s noisy because another lady is t at night."			the comment form is reviewed by the social worker and addressed in a time manner. Residents; grievances and concerns are routinely reviewed dur the shift-to-shift reports, quarterly car conferences, and the Quality Assess and Assurance Committee meeting During the mandatory meetings July 15 and 16, 2015, the staffs were report of the residents; right to report grievances and care concerns and responsibility to respond appropriate in a timely manner. Discussion will if the residents; right to have 1) custor routines respected and accommoda fullest extent possible and 2) a quie environment that promotes restful s The staff were reminded of the procedures to alert the social worked other appropriate staff of their concerns/observations and the com- expressed by the residents/families Residents; rights are reviewed with staff annually and are included as p new employee orientation. Satisfaction with cares and services continue to be discussed during each often as necessary. Residents will b asked about their satisfaction with r levels during the night during the ne- three resident council meetings.	mely d ring are sment s. y 14, minded their ely and include omary ated to t sleep. er and cerns on the wart of s will ch ore obe noise ext	
	or communication				The record of resident number 30 w reviewed; there was no recent documentation of incidences of nigh		

Facility ID: 00429

If continuation sheet Page 3 of 97

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		E SURVEY PLETED
		245349	B. WING _			06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COI	DE	
STEWAF	TVILLE CARE CENTI	ER			JRTH STREET NORTHEAST ARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 166	on 6/11/15 at 2:32 p [R30] yells a lot at r During an interview licensed practical n a problem yelling an try to medicate her happens at least a roommate has said night. Everybody is (SS), the director of why we can't fix it." During an interview 9:55 a.m., LPN-K s but it has been a pr night. She cries ou noise, about 1-2 tim know about it but it During an interview p.m., SS-A stated, ' grievances for the about (R30) crying grievance form abo grievance form on a residents to use the to get to her (R30) a hollers and cries ou	o.m., NA-D said, "I have heard hight from the night staff." on 6/11/15, at 2:41 p.m. urse (LPN)-J said, "(R30) has nd cries at night. The staff will and sit with her. This couple times a week. Her she (R30) has kept her up all aware of it, social services f nursing (DON). I don't know with LPN-K on 6/12/15 at tated, "(R30) slept last night oblem with her yelling in the t at night or at least makes hes a week. SS and the DON is a difficult issue to resolve." with SS-A on 6/11/15 at 2:56 'I don't have any written past six months. I have heard out but I have not gotten a ut it. Everyone is given a admission. We do not remind e grievance form. The staff try as fast as they can but she still it."	F 16	yelli will to d num resid for s will nigh incid tear beh to p resid prace sym resid resid the resid infol rega resid the resid for t ther resid for s will for t the resid for s will for t the resid for s vill for t the resid for s vill for t the resid for s vill for t the resid vill for t the resid vill for t	ng. The Assistant Director meet with the nurses on the iscuss the past behavior of the 30 disturbing the sleet dents. The resident will be symptoms of pain and here be monitored and docume that for 14 nights. If there a dences of yelling, the inter m will meet to assess the avior and discuss further is romote a restful environm dent;s attending physicia citioner will be notified of la optoms adversely impacting dents. Sident number 53 - The star rend of the resident;s co arding the sleep disturbing dent number 30. The staff night time behavior patter dent number 30 and imple rventions to minimize the ear by residents. The soc interview the resident at le three weeks to determine the are ongoing concerns re- at time noise levels. If com- ced, additional monitoring alternative interventions	he night staff of resident ep of near by e reassessed sleep habits ented for are continued rdisciplinary resident is interventions tent; the n/nurse behavior ng other aff have been incern g behavior of f will monitor ns of ement disturbance ial worker east weekly whether egarding the cerns are	
	people awake at nig aware of the daytim knew the grievance "repaired." An undated facility	ot aware [R30] was keeping ght but acknowledged, "I was ie noises." The DON stated he process needed to be policy entitled, Filing aints indicated: "Grievances		Res info rega resi use	mpted/implemented. ident number 46 - The sta rmed of the resident¿s co arding the sleep disturbing dent number 30 and the s d by her roommate. The s hitor the night time behavio	ncern g behavior of afety alarms staff will	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		0938-039
	N OF CORRECTION IDENTIFICATION NUMBER:			ING	(X3) DATE SURVEY COMPLETED 06/17/2015	
		245349	45349 B. WING			
NAME OF	PROVIDER OR SUPPLIER					
STEWA	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 166	and/or complaints i writingthe admini responsibility of gri investigation to Soc grievance and/or co investigate the alle report of such findi	age 4 may be submitted orally or in strator has delegated the evance and/or complaint cial Services. Upon receipt of a omplaint, Social Services will gation and submit a written ng to the administrator within f receiving the grievance	F1	 resident number 30 and the use h roommate;s safety alarms. The s worker will interview the resident a weekly for three weeks to determ whether there are ongoing concer regarding the night time noise lev Interventions to minimize the nois will be discussed/implemented an resident;s ongoing satisfaction w staff responses to concerns will b addressed as necessary. The res was visited by the social worker J 2015 and she expressed interest moving to a different room. She is ¿content and agreeable; with the be offered the first window beds th become available. Resident number 7 - The staff har informed of the resident;s concer regarding the sleep disturbing bef resident number 30. When questid during her care conference July 1 the resident stated that the behav resident number 30 were not distu- her sleep. The social worker will in the resident at least weekly for the weeks to determine whether there ongoing concerns regarding the m noise levels. If concerns are voice additional monitoring will be done alternative interventions attempted/implemented. Resident number 66 - The staff har informed of the resident;s concer regarding the sleep disturbing bef resident number 30. The staff will the night time behavior patterns or 	ocial at least ne ins els. e levels d the ith the e ident uly 14, in plan to nat ve been n avior of oned 4, 2015, iors of urbing nerview ee e are ight time ed, and ave been n avior of monitor	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORI	D: 07/17/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245349	B. WING			6/17/2015
NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 F 223 SS=K	ABUSE/INVOLUN The resident has th sexual, physical, an punishment, and in The facility must no	c)(1)(i) FREE FROM TARY SECLUSION ne right to be free from verbal, nd mental abuse, corporal ivoluntary seclusion. bt use verbal, mental, sexual, corporal punishment, or	F 1		resident number 30 and implement interventions to minimize the disturbance of near by residents. The resident resides across and down the hall from resident number 30 and has a very severe hearing deficit when not wearing her hearing aide which she removes at night. The social worker will interview the resident at least weekly for three weeks to determined whether there are ongoing concerns regarding the night time noise levels. If concerns are voiced, additional monitorin will be done and alternative interventions attempted/implemented. The night nurses will document the behaviors of resident number 30 nightly for 14 nights; the data will be assessed to determine whether additional intervention are necessary to address night time behaviors. The Social Worker will monito resident satisfaction with a restful sleep environment during one-to-one visits, car conferences, and resident council meetings for the next 90 days and randomly thereafter.	s g g r

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ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-039 (X3) DATE SURVEY	
ID PLAN (OF CORRECTION			G		COMPLETED 06/17/2015	
		245349	B. WING		06/-		
IAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
STEWAF	TVILLE CARE CENT	ER					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
F 223	This REQUIREMENT is not met as evidenced		F 22	3			
	review, the facility f (R75 and R65) rev from verbal and ph facility staff were a not immediately rej further abuse from to implement interv abuse resulted in a R75, R65 and othe main and lower floo perpetrator worked The IJ began on 4/ observed the abus preventative interve residents with cogr immediately report abuse from reoccu (DON) and adminis immediate jeopard noncompliance rer severity level of G, level, actual harm hand) that is not im Findings include: Although R75 was	² 24/15, when facility staff had e but failed to implement entions, failed to provide initial ation to staff for use of ntions when dealing with nitive deficits, and failed to the abuse as efforts to prevent irring. The director of nursing strator were notified of the y at 3:00 p.m. on 6/12/15. The y was removed on 6/16/15, but nained at a lower scope and isolated scope and severity (bruising and swelling of R65's		 Preparation, submission and implementation of this Plan of does not constitute an admis agreement with the facts and set forth in the statement of of The facility has appealed the and licensing violations state Plan of Correction is prepare executed as a means of con improve the quality of care, t all applicable state and feral requirements and constitutes allegation of compliance. Stewartville Care Center polit that each resident be free from sexual, physical, and mental corporal punishment, and invise clusion. The resident will r subjected to abuse by anyone but not limited to, facility staff residents, consultants, volum other agencies serving the remembers or legal guardians, individuals. The facility is policies and prinvestigating/reporting of incireviewed and found approprint facility is Vulnerable Adult Ab were distributed to all staff or June 17, 2015. The staff were sign to verify that they receivered and four proventing of the staff were sign to verify that they receivered and four proventing of the staff were distributed to all staff or June 17, 2015. The staff were sign to verify that they receivered and four proventing of the staff were distributed to all staff or June 17, 2015. The staff were sign to verify that they receivered and four proventing of the staff were distributed to all staff or June 17, 2015. The staff were staff were	of Correction ssion of or d conclusions deficiencies. e deficiencies ed herein. This ed and/or tinuously o comply with regulatory s the facility¿s icy requires om verbal, abuse, voluntary not be ne, including, f, other teers, staff of esident, family , or other		

Facility ID: 00429

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	OMB NO.	0936-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G	· · /	PLETED
		245349	B. WING			17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 223	Continued From pa	age 7	F 22	3		
	interventions initiate A facility COMPLAI REGARDING an E completed by nursi 4/25/15. The conce [LPN-E's first name CONCERN: Upon residents from supp heard a lot of comr that the nurse [LPN at resident [R75]. V her room, she [R75] question and he sta That's when we rer situation" R75's quarterly min 5/12/15 indicated F mental status (BIM R75 was severely of also indicated R4 c difficulty. During an interview 9:51 a.m., R75 was with family (F)-A. F the surveyor withou	ected staff to provide, "Clear,		 were instructed on the following definition of a vulnerable adult a mandated reporter of actual or resident abuse/neglect/misappe of property 3) the types of incid must be reported to the common point and/or the Minnesota Dep Health 4) the requirements of in reporting of alleged abuse/negl misappropriation of funds to the supervisory/administrative staff appropriate governmental ager 5) forms and procedures for ap and timely reporting. The staff i on vulnerable adult issues at le twelve months; vulnerable adult investigation and reporting are during new employee orientation. The employee (LPN-E) involved April 24, 2015 incidents with resnumber 65 and 75 was initially for three days pending an invest the alleged abuse. After returni he was assigned to another care After the June 2015 state review issue, the LPN-e was requested complete a Health Professiona Program evaluation as a condit continued employment. The provide treatment/counseling. 	2) who is a suspected opriation ents that on entry partment of nmediate ect and e and ncies and propriate s educated ast every t addressed n. d in the sidents suspended stigation of ng to work, re unit. w of the d to Services ion of ogram thich	
	needed to facilitate Information provide investigation of the interview conducted	epeat/rephrase words as hearing and comprehension." ed by the DON related to the se incidents, included a typed d 4/25/15 at 10:00 a.m., by the he interview documentation		employee returned to work and no further practice/performance Resident number 65 ¿ The res continues to wander throughou floor of the facility. She has had	e issues. ident t the first	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COM	PLETED	
		245349	B. WING			06/-	17/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 223	Friday 4-24-15 p.m was talking to [R75 questions and as [I questions he was k yelling, and was pro-	age 8 o [NA-L] concerning incident a. shift. She stated he [LPN-E] i]. [R75] was repeating LPN-E] was answering becoming more upset and obably yelling more than he standing nearby with her	F 2	23	altercations with staff; her usual resistiveness to bathing continues. resident has severe cognitive impa and believes that she works at the and is a care taker for her grandpa She does not recall the incident fro 2015. The social worker frequently	airments facility arents. om April		
	walker but did not s (NA-L) heard a little (certified nursing a at staff, kicking and her walker."	say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with ount of these incidents had			interacts with the resident as she were the social service office several time day. The social worker will meet were sident weekly for four weeks and monthly for six months to assess meand behavior. The care plan was mand found appropriate.	valks by nes a ith the I then nood		
	been documented account included, " for staff potluck, ow member [LPN-E] a see who it was but [R75]. Went out for when a staff memb had stated 'could ju back in I asked [LF 'we had a call in for grandson was back call to see if I could night shift, he said page from another (RN)-H], had me co and talk with [assis (ADON) RN-A]. Dis	by LPN-J on 4/25/15. LPN-J's On Friday 4/24/15 I was here verheard loud voice of a staff ddressing a resident. I did not another staff stated it was r a smoke break after eating, ber came out and said [LPN-E] ust kill them all'. When I came PN-E] if he was ok, he stated r night shift', (he also said his k in the hospital.) I offered to d get someone to come in for that would be great. Received staff [registered nurse ome down to the breakroom tant director of nursing scussed issue regarding decided [LPN-E] would be			Resident number 75 ¿ The resider cognitive deficits and self-propels I wheelchair around the facility. She occasional negative interactions w residents which require staff interv She does not recall the incident fro 2015. The social worker will meet resident weekly for four weeks and monthly for six months to assess r and behavior. The resident frequer visits the Social Worker¿s office w obtain a piece of candy from the ca bowl. The care plan was reviewed found appropriate. The Social Worker will monitor compliance by auditing incident rep timely and appropriate notification	her has ith other ention. om April with the then nood htly ork to andy and corts for of the		
	statements, followi R75, LPN-E was in However, LPN-E c	iews and written witness ng the verbal altercation with structed to go home. ontinued to remain in the inuous supervision or			administrator and government offic the next three months. If noncomp is noted, additional auditing and sta training will be done. Compliance w reviewed during the September Qu Assessment and Assurance Comm	liance aff vill be Jality		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		. 0938-039 E SURVEY IPLETED
		IDENTIFICATION NOWDER.	A. BUILDI	NG		
		245349	B. WING			/17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 120 FOURTH STREET NORTHEAS		
STEWAR	TVILLE CARE CENT	ER		STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 223	Continued From pa	ige 9 from resident access.	F 2	23 quarterly meeting and one	aoina.	
	LPN-E verbally and the altercation with R65 sustained an in facility's time clock punched out from h	Physically abused R65 after R76. During that altercation njury to her left hand. The records indicated LPN-E had his shift at 7:37 p.m., hour after the incident of			joniy.	
	note in R75's media (7:38 p.m.) which ir 4/24/15. Several sta conference room w raising his [LPN-E] writer came out in a resident [R75] need to her room." The stated, "she can dri to go," and had the about arguing with documented, "Able	to redirect the resident and DON, ADON and social				
		ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the ccility.				
	had an active Minn had been employed 2015. Review of Ll record indicated tha Abuse Protocol trai had not received tra cognitively impaired the incidents of alle	record was reviewed. LPN-E esota Nursing License and d at the facility since January PN-E's in-service training at LPN-E had received initial ning during orientation, but aining on dealing with d residents since hire until after ged abuse on 4/24/15. LPN-E ne education related to Abuse				

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ ⁻	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Prohibition/Resider Alzheimer's client of During an interview p.m., NA-C recalled stated, "I was sitting heard [LPN-E] yellin NA-C then explaine hallway near the nur re-direct R75, "We but then she [R75] question and he sta her again. We were from the situation." remember what LP screaming about. During an interview indicated she could that had taken plac However, she state heard LPN-E yelling remember what had confrontation but st least 10 minutes. N been interviewed al aware she could re agency. During an interview DON was asked to regarding the imme allegations of abuse residents to the adr and any intervention other residents, or a incident. The DON the allegation involve	nt rights/Caring for the	F 2	223			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From pa physical abuse alleg R65. During a follow-up i at 2:34 p.m., NA-C after dinner which v stated, "[LPN-E] wa him down the hallw yelling was all abou was in her face yell the wheelchair, and confused than usua after the incident R man was yelling at me?" until she went besides the repeate anxious and quiet th went to bed. NA-C who she'd told abou The facility COMPL REGARDING an El NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L] grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4/2	ge 11 gation between LPN-E and nterview with NA-C on 6/12/15 stated the yelling had started vas around 6:30 p.m. NA-C is really loud, we could hear ay. We went to see what the t, when we went up there, he ing at her, she was sitting in 1 think [R75] was more al." NA-C further explained that 75 had kept repeating, "That me, why was he yelling at to bed. NA-C stated that ed question, R75 had been he rest of the night until she stated she could not recall at the incident. AINT/CONCERN FORM MPLOYEE completed by so included:"Around 7:40 ask nurse [LPN-J] a question at [R65] standing by the med PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to went over and intervened. I int [R65] down afterwards but d up."	F 2		DEFICIENCY)		
	4/25/15 by LPN-J a regarding [LPN-E] a would be asked to g	5, had been documented on nd included: "Discussed issue and it was decided [LPN-E] go home. He was finishing up at cart when [R65] came up,					

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PRINTED: 07/17/2015

	-	AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	grabbed the water p with it. He grabbed back on cart. She th to hit him with it, no she dropped it but i picked it up and [Re closed fist at which asked [R65] to leav [LPN-E] left shortly Another witness sta physical abuse of F RN-H on 4/25/15 at the interaction betw 4/24/15 as I was or [RN-A]. I was inforr gotten in [LPN-E's] fact that [LPN-E] ha around [R65] until 1 [NA-C] is filling out was reported to my aware of this situati had occurred by [LF soon as able." R65's quarterly MD R65 had a BIMS so cognitive impairment R65's care plan ver demonstrated beha interventions includ receptive when she her using calm, dire Review of R65's me certified nurse prace	pitcher, and tried to hit him it out of her hands and set it hen raised up her walker, as if of sure if he knocked it down or it fell on the floor. [LPN-E] 65] went as if to hit him with a time I got between them and we the area which she did. after that." atement regarding the alleged R65 had been documented by nd included: "I did not witness ween [LPN-E] and [R65] on n phone [symbol for with] med by [LPN-J] that [R65] had face but was unaware of the ad put his arm and hand 11 p.m. on 4/24/15. CNA an incident report stating it vself and [LPN-H]. I was made ion 4 hours [symbol for after] it PN-B]. I reported incident as PS dated 4/28/15, indicated core of 4 indicating severe nt. rified the resident avioral problems and led: "She is much more e has familiar staff working with ect approach."	F 223			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245349	B. WING	i		06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	documented as an physical assault." T included: "Charge r patient was physica on April 24, 2015. A the patient had bee another eyewitness the event. Patient had laryngeal edema, si Director of nursing notified. A vulnerab Olmsted County. N patient be evaluated assault. Patient has her neck. There is n evidence of finger p area. She has some her left hand and nu some mild soft tissa after the incident with An additional entry at 6:18 p.m. include informed me that pa with a staff nurse of was agitated and at pitcher at the nurse grabbed the patient water pitcher with th some mild swelling thumb web space v incident. Today she noted on her left ha her left thumb after resolved. Director of were notified. A vul-	age 13 "Evaluation of patient after The documented assessment hurse has informed me that ally assaulted by a staff nurse According to the charge nurse, on placed in a chokehold per a. No bruising was noted after had no difficulty breathing, no tridor, or tracheal deviation. and Social Services were le adult form was filled with ursing is requesting that d for any potential injury from a no evidence of any trauma to no bruising, abrasions, orints on her neck or shoulder e resolving bruising noted on urse reported that she has ue swelling of her left thumb hich has now resolved" written by CNP-D on 4/28/15 ed, " Charge nurse has atient [R65] had an altercation n April 24, 2015. The patient ttempted to throw her water a. The nurse reached and t's wrist with one hand and the he other hand. There was noted on the patient's left with a bruise occurring after the a has some resolving bruising and and no further swelling of the incident which has now of Nursing and Social Services nerable adult form was filled ty. Nursing is requesting that d for any potential injury from a [R65] denies all complaints of		2223			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING	i		06/ ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF		ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	pain today. Patient trauma to her body or change in her fur During an interview regards to when he incident with R65 w evening meal, DON phone message on incident but he did morning (Saturday come to the facility The DON stated it w director of nursing, administrator, or so internal investigativ designated agency. The facility provided submission report t Health Facility Com investigative notes According to the re allegations were no allegation of physic been reported the of 4/25/15. There had allegation of verbal documentation indi- had been submitted report included LPN abuse of R65 how witness accounts o and accounts from the CNP's assessmi indicated R65 had s	has no evidence of any with no bruising or abrasions, nctional status" on 6/11/15, at 9:34 a.m. in was notified of the abuse which occurred on 4/24/15 after stated staff had placed a his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, pcial worker to submit any e reports to the State		223			

		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	assessment completed by the investigative repersonal improvem included education dementia training, for report to the board to another unit. During an interview 9:45 a.m., the DON counseling, educati behaviors especiall might become agitate the DON stated the followed-up with LF incidents for R75 and employed by the fadocumentation as the was working on in reporting and stress in a abuse situations for R75 and been required that LP Protocol training dureceived training or impaired residents incidents of alleged RN-A verified that LP Protocol training dureceived training or impaired residents incidents of alleged RN-A verified that for the protocol training dureceived training or impaired residents incidents of alleged RN-A verified that for the protocol training dureceived training or impaired residents incidents of alleged RN-A verified that for the protocol training dureceived training or impaired residents incidents of alleged RN-A verified that for the protocol training dureceived training or impaired residents incidents of alleged RN-A verified that for the protocol training for the protocol training for the protocol training or impaired residents incidents of alleged RN-A verified that for the protocol training for	eted on 4/28/15 verified there and bruising of R65's left wrist. eport also documented a lent plan for LPN-E that re., vulnerable adult and follow up with social worker, of nursing, and reassignment with the DON on 6/12/15 at I stated LPN-E receiving ion on dealing with difficult ly residents with dementia who ated and combative. However, e social worker who had PN-E after the alleged abuse nd R65 was no longer cility and there was no to what improvements LPN-E regards to his performance petence of handling agitated ehaviors, or dealing with a healthy manner to prevent om redeveloping. Wed on 6/12/15, at 11:57 a.m. PN-E had received initial Abuse uring orientation, but had not n dealing with cognitively since hire until after the I abuse on 4/24/15. ollowing the incidents, LPN-E to complete online education rohibition/Resident e Alzheimer's client on 4/28/15.	F	223			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245349	B. WING _			06/ ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	the State agency (C abuse R75 had sus was made on 6/12/ plan of correction for been informed that situation existed. The the State agency in [Minnesota Departh to this writer's atten [LPN-E] was yelling was initially reporter another demented of the main focus of the information in regar investigation of R65 was also agitated a responding to re-din at resident due to h [R75] and her conti- initially combined be nurse [LPN-E] into a now reporting this p separate incident On 6/16/15 all staff facility's abuse prote- from the assistant of reported for work. read the packet of i abuse protocol. The policies entitled: Ba Investigations, In-S Resident Abuse, Re Symptoms of Abuse Reporting/Investigation, Prote- Abuse Investigation, Prote-	DHFC) regarding the verbal stained on 4/24/15. The report 15, as part of the immediate ollowing the facility having an immediate jeopardy he incident description sent to icluded: "During routine MDH ment of Health], it was brought at resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was hat OHFC report and rds to R75 was to support the 5. During this incident [R75] and following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a ." received a copy of the ocol packet (forms undated) director of nursing as they The staff were requested to information in regards to ne packet included specific ackground Screening ervice Training, Preventing ecognizing Signs and e/Neglect,	F 2	23			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245349	B. WING	à		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	·		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENT	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	Reporting Suspecter Rape, Vulnerable A Misappropriation of Investigating Unexp Resident-to-Resider In addition the pack- undated facility poli Life-Dignity, Employ Keys to Resident Li and Indicators of N Interviews were con- direct care staff, ac and supervisory nu- shifts on 6/16/15 be p.m. to verify receip their shifts. Each st they had received a were in the process facility's IJ removal RN-A was interview RN-A stated all staff described as they r Facility policies rela- reviewed. An undatt Reporting/Investiga Accidents/incidents reported to the dire- immediately to the accidents/incidents thoroughly investiga findings of such inv- by the Director of N An undated policy of Investigation includ	ed Cases and/or Incidents of adult Reporting of Alleged f Residents Personal Property, plained Injuries, ent Abuse, and reporting forms. Ket of information included icies for Visitation, Quality of yee In-Service Program, Six oyalty, Indicators of Abuse, eglect. Inducted by survey staff with stivities staff, pool nursing staff, rrsing from day and evening etween 2:20 p.m. and 2:40 of of education prior to starting taff person interviewed verified a packet of information and s of reading it as detailed in the plan. Wed on 6/16/17 at 2:45 p.m ff were provided training as reported to work. ated to Abuse Prohibition were ted policy entitled ating Resident s included: "All involving residents must be foctor of nursing services and administratorAll involving residents will be ated by management and the vestigation will be kept on file	F	223	3		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245349	B. WING			06 / ⁻	17/2015
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From pa investigated."	ge 18	F 2	223			
F 225 SS=K	State Agencies and included, "All allege substantiated incide immediately to the A reported to appropr The immediate jeop was removed on 6/ determined the faci plan for removal in as they reported to policies related to a and reporting prior to residents. In addition been developed and complaince with face non-compliance rem 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit	(c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a c an employee, which would or service as a nurse aide or the State nurse aide registry ties.	F 2	225			6/17/15
		sure that all alleged violations ent, neglect, or abuse,					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	0	(X3) DATE	E SURVEY PLETED
		245349	B. WING _			06 /1	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
STEWAF	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTH STEWARTVILLE, MN 559			
				,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD TO THE APPROPF	BE	(X5) COMPLETION DATE
F 225	misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must haviolations are thorop prevent further pote investigation is in pu The results of all inv to the administrator representative and with State law (inclu- certification agency incident, and if the a	unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 2	5			
	by: Based on observat review, the facility fa allegations of verba administrator and S thoroughly investiga neglect, and/or mis (R75, R65) reviewe ensure residents we abuse. The facility's abuse/neglect/malt following identification resulted in an immediate for R75 and R65 as who resided on the	NT is not met as evidenced ion, interview and document ailed to immediately report al and physical abuse to the state agency, failed to ate allegations of staff abuse, treatment for 2 of 5 residents d for abuse, and failed to ere protected from further s failure to operationalize their reatment policy/procedures on of abuse to R75 and R65, ediate jeopardy (IJ) situation s well as for other residents main and lower floor living ged perpetrator worked,		Preparation, submiss implementation of this does not constitute an agreement with the fa- set forth in the statem The facility has appea and licensing violation Plan of Correction is p executed as a means improve the quality of all applicable state and requirements and con allegation of complian	s Plan of Corre n admission of acts and conclu- tent of deficient aled the deficient as stated here prepared and/ of continuous care, to comp and feral regulationstitutes the far ace.	of or usions ncies. encies in. This or sly bly with tory ucility¿s	

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PRINTED: 07/17/2015

						MB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245349	B. WING _			06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225	Continued From pa	lge 20	F 22	25			
	presenting a risk of neglect, and/or mis In addition the facili abuse/neglect polic reporting, investiga residents if allegatic and mistreatment fr reviewed (R64, R99 The immediate jeop facility staff witness (LPN)-E verbally at abuse R65. The di administrator were jeopardy at 3:00 p.r The immediate jeop but noncompliance and severity level of severity of no actual than minimal harm jeopardy. Findings include: Although R75 was at by licensed pract following the supper subsequently obset physically abusive thowever, the incide	additional staff abuse, treatment. ity failed to operationalize their ty that clearly identified tion, and protection of on/s of staff abuse, neglect, or 3 of 6 other allegations 9, and R98). oardy began on 4/24/15 when the licensed practical nurse buse R75 and then physically rector of nursing (DON) and notified of the immediate			that all alleged violations involving resident mistreatment, neglect, abuinjuries of unknown source and misappropriation of property be 1) reported immediately to the administrative state agencies and thoroughly investigated in a timely rewith the investigative results reported the administrative staff and state of as required. If the alleged violation verified, appropriate corrective action be taken. The facility intervenes to further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who he been found guilty of abusing, negle or mistreating residents. Any knowl of actions against an employee whi would indicate unfitness for service resident care position is investigate reported to the State nurse aid regi- licensing authorities. The facility is policies and procedures for investigation/reporting of incidents of reviewed and found appropriate. The facility is Vulnerable Adult Abuse po- were distributed to all staff on June June 17, 2015. The staff were requising number of the information.	strator 1 2) manner ed to ficials is on will prevent nave cting, edge ch in a d and stry or were ne blicies 16 and ired to	
	abuse. A facility COMPLAI REGARDING an E completed by nursi	ONS initiated to prevent further NT/CONCERN FORM MPLOYEE had been ng assistant (NA)-C dated ern included: "EMPLOYEE			On June 16, 2015, all Stewartville C Center staff including management were instructed on the following: 1) definition of a vulnerable adult 2) w mandated reporter of actual or sus resident abuse/neglect/misappropri	the the ho is a pected	

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	-	AND HUMAN SERVICES				FORM	07/17/2018 APPROVEE 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· /	SURVEY PLETED
		245349	B. WING			06 /1	7/2015
NAME OF	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	NAME: [LPN-E's fir CONCERN: Upon in residents from supple heard a lot of commithat the nurse [LPN at resident [R75]. Wher room, she [R75] question and he stat That's when we remisituation" R75's quarterly min 5/12/15 indicated R mental status (BIM: R75 was severely of also indicated R4 c difficulty. During an interview 9:51 a.m., R75 was with family (F)-A. F the surveyor without surveyor did not hat to hear. R75's care plan direct careful, explanation comprehensionref needed to facilitate Information provide investigation of these interview conducted DON with NA-L. Thi included, "Spoke to Friday 4-24-15 p.m was talking to [R75 questions and as [L]	ected staff to provide, "Clear,	F2	225	of property 3) the types of incidents must be reported to the common er point and/or the Minnesota Departm Health 4) the requirements of imme reporting of alleged abuse/neglect a misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies 5) forms and procedures for approp and timely reporting. The staff is ed on vulnerable adult issues at least et twelve months; vulnerable adult investigation and reporting are addr during new employee orientation. The employee (LPN-E) involved in t April 24, 2015 incidents with resider number 65 and 75 was initially susp for three days pending an investigat the alleged abuse. After returning to he was assigned to another care un After the June 2015 state review of issue, the LPN-e was requested to complete a Health Professional Ser Program evaluation as a condition of continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has no further practice/performance issue Resident number 75 ¿ The resident cognitive deficits and self-propels he wheelchair around the facility. She occasional negative interactions wit residents which require staff interve She does not recall the incident fror 2015. The social worker will meet w resident weekly for four weeks and	and and and and and oriate ucated every ressed the nts bended tion of o work, nit. the vices of m had ues. t has er has h other ention. m April <i>i</i> th the	

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		& MEDICAID SERVICES			0		0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY PLETED
		245349	B. WING			06 /1	17/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 225	should. [R65] was walker but did not s (NA-L) heard a little (certified nursing a at staff, kicking and her walker." Another typed acco been documented account included, " for staff potluck, ow member [LPN-E] a see who it was but [R75]. Went out for when a staff memb had stated 'could ju back in I asked [LF 'we had a call in for grandson was back call to see if I could night shift, he said page from another (RN)-H], had me co and talk with [assis (ADON) RN-A]. Dis	obably yelling more than he standing nearby with her say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with ount of these incidents had by LPN-J on 4/25/15. LPN-J's 'On Friday 4/24/15 I was here verheard loud voice of a staff ddressing a resident. I did not another staff stated it was r a smoke break after eating, ber came out and said [LPN-E] ust kill them all'. When I came PN-E] if he was ok, he stated r night shift', (he also said his k in the hospital.) I offered to d get someone to come in for that would be great. Received staff [registered nurse ome down to the breakroom stant director of nursing scussed issue regarding decided [LPN-E] would be	F 2	225	monthly for six months to assess r and behavior. The resident frequen- visits the Social Worker; s office to a piece of candy from the candy bo care plan was reviewed and found appropriate. Resident number 65 ; The reside continues to wander throughout the floor of the facility. She has had no altercations with staff; her usual resistiveness to bathing continues. resident has severe cognitive impa- and believes that she works at the and is a care taker for her grandpa- She does not recall the incident fro 2015. The social worker frequently interacts with the resident as she w the social service office several tim day. The social worker will meet w resident weekly for four weeks and monthly for six months to assess r and behavior. The care plan was r and found appropriate. Residents number 64 ; The allege abuse by the resident;s spouse w observed 4/15/15 at 4:40 pm and v reported to the State agency until t	ntly o obtain owl. The nt e first o recent . The airments facility arents. om April valks by nes a ith the d then nood eviewed ed as was not	
	statements, followi R75, LPN-E was in However, LPN-E c facility without cont immediate remova LPN-E verbally and	iews and written witness ng the verbal altercation with istructed to go home. ontinued to remain in the inuous supervision or I from resident access. d physically abused R65 after R76. During that altercation			day. The related facility policy and regulatory requirements for immed reporting were reviewed by the administrative and social service s quality improvement purposes. Resident number 99 ¿ The resider at the facility September 15, 2014.	the liate taff for nt died	

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	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
		245349	B. WING	۵ <u>ـــــ</u>	06/2	7/0015	
NAME OF	PROVIDER OR SUPPLIER	210010		STREET ADDRESS, CITY, STATE, ZIP CC		17/2015	
		ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 225	approximately one verbal abuse with F RN- H had docume note in R75's media (7:38 p.m.) which in 4/24/15. Several st conference room w raising his [LPN-E] writer came out in a resident [R75] need to her room." The stated, "she can dr to go," and had the about arguing with documented, "Able diffuse the situation services all notified LPN-E was observed conducting a media lower level of the fat LPN-E's personnel had an active Minn had been employed 2015. Review of L record indicated that Abuse Protocol trait had not received tr cognitively impaired the incidents of alle had completed onli	his shift at 7:37 p.m., hour after the incident of R75 had occurred. ented a late entry progress cal record on 4/27/15 at 19:38 ncluded, "Late entry from aff members were in the south when a staff nurse was heard voice towards resident. This attempts to ascertain what the ded. Asked if she wanted to go notes indicated LPN-E had ive herself wherever she wants en made some comments her. RN-H further to redirect the resident and h. DON, ADON and social d of incident." ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the acility. record was reviewed. LPN-E lesota Nursing License and d at the facility since January PN-E's in-service training at LPN-E had received initial ining during orientation, but aining on dealing with d residents since hire until after eged abuse on 4/24/15. LPN-E ine education related to Abuse ht rights/Caring for the on 4/28/15.	F 22	 incident during the morning of 2014 not being submitted un afternoon was reviewed by the management staff for continuimprovement purposes. Resident number 98 ¿ The mat the facility December 29, 2 circumstances regarding the delay in reporting a bruise to administrator and State ager reviewed by the managemer continuing quality improvemed. The Social Worker will monit compliance by auditing incide timely and appropriate notific administrator and State ager next three months. If noncomnoted, additional auditing and be done. Compliance will be during the September Quality and Assurance Committee queeting and ongoing. 	til the ne uing quality esident died 2014. The 48-hour the ncy were nt staff for ent purposes. or ent reports for tation of the ncies for the npliance is d training will reviewed y Assessment		

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	stated, "I was sitting heard [LPN-E] yellin NA-C then explained hallway near the nu- re-direct R75, "We but then she [R75] question and he sta her again. We were from the situation." remember what LP screaming about. During an interview indicated she could that had taken plac However, she state heard LPN-E yelling remember what ha confrontation but st least 10 minutes. N been interviewed al aware she could re agency. During an interview DON was asked to regarding the imme allegations of abuse residents to the adr and any interventio other residents, or a incident. The DON the allegation involv because he had be physical abuse alle R65. During a follow-up i	age 24 g in the back nursing area, we ng and screaming at [R75]." ed she had walked up the urse's station and was able to started walking away with her asked him [LPN-E] another arted yelling and screaming at e finally able to remove her NA-C stated she could not 'N-E was yelling and ' on 6/11/15 at 6:00 p.m., NA-E a not recall all of the events the evening of 4/24/15. ed she could remember she'd g at R75. NA-E could not d been said during the tated the yelling had lasted at IA-E also stated she had never bout the incident and was not port abuse to the State ' on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the the between LPN-E and the ministrator or State agency, ns taken to protect R75 or any investigation of the abuse confirmed he had not reported ving R75 to the State agency een more focused on the gation between LPN-E and	F 2	225			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY IPLETED
		245349	B. WING		06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	after dinner which w stated, "[LPN-E] wa him down the hallw yelling was all about was in her face yell the wheelchair, and confused than usua after the incident R man was yelling at me?" until she wen besides the repeate anxious and quiet t went to bed. NA-C who she'd told about The facility COMPL REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4// investigation for R6 4/25/15 by LPN-J a regarding [LPN-E] a would be asked to a a medication admir grabbed the water pi with it. He grabbed back on cart. She ti to hit him with it, no	was around 6:30 p.m. NA-C as really loud, we could hear vay. We went to see what the ut, when we went up there, he ling at her, she was sitting in d I think [R75] was more al." NA-C further explained that 75 had kept repeating, "That me, why was he yelling at t to bed. NA-C stated that ed question, R75 had been he rest of the night until she stated she could not recall ut the incident. LAINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but	F 225			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING	i		06/ [.]	17/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	closed fist at which asked [R65] to leav [LPN-E] left shortly Another witness sta physical abuse of F RN-H on 4/25/15 ar the interaction betw 4/24/15 as I was on [RN-A]. I was inform gotten in [LPN-E's] fact that [LPN-E] ha around [R65] until 1 [NA-C] is filling out was reported to my aware of this situati had occurred by [Lf soon as able." R65's quarterly MD R65 had a BIMS so cognitive impairment R65's care plan ver demonstrated beha interventions includ receptive when she her using calm, direc Review of R65's me certified nurse pract requested to condu 4/28/15. The CNP' documented as an physical assault." T included: "Charge r patient was physica	65] went as if to hit him with a time I got between them and e the area which she did. after that." atement regarding the alleged 65 had been documented by nd included: "I did not witness veen [LPN-E] and [R65] on n phone [symbol for with] ned by [LPN-J] that [R65] had face but was unaware of the ad put his arm and hand 1 p.m. on 4/24/15. CNA an incident report stating it self and [LPN-H]. I was made on 4 hours [symbol for after] it PN-B]. I reported incident as S dated 4/28/15, indicated core of 4 indicating severe nt. ified the resident wioral problems and ed: "She is much more has familiar staff working with ext approach." edical record indicated a titioner (CNP)-D had been ct an assessment of R65 on	F	225			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245349	B. WING	i		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER					
		TEMENT OF DEFICIENCIES		3	STEWARTVILLE, MN 55976 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 27	F	225			
		n placed in a chokehold per					
		s. No bruising was noted after ad no difficulty breathing, no					
	laryngeal edema, s	tridor, or tracheal deviation.					
		and Social Services were le adult form was filled with					
		ursing is requesting that					
		d for any potential injury from					
		s no evidence of any trauma to no bruising, abrasions,					
	evidence of finger p	prints on her neck or shoulder					
		e resolving bruising noted on urse reported that she has					
		ue swelling of her left thumb					
		hich has now resolved"					
		written by CNP-D on 4/28/15					
		ed, " Charge nurse has atient [R65] had an altercation					
		n April 24, 2015. The patient					
		ttempted to throw her water					
		e. The nurse reached and I's wrist with one hand and the					
	water pitcher with th	he other hand. There was					
		noted on the patient's left					
		with a bruise occurring after the has some resolving bruising					
	noted on her left ha	and and no further swelling of					
		the incident which has now of Nursing and Social Services					
		nerable adult form was filled					
		ty. Nursing is requesting that					
		d for any potential injury from [R65] denies all complaints of					
	pain today. Patient	has no evidence of any					
		with no bruising or abrasions,					
	or change in her fu	notional status					
	During an interview	on 6/11/15, at 9:34 a.m. in					

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		AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245349	B. WING		06/ [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER		Ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAF	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	regards to when he incident with R65 w evening meal, DON phone message on incident but he did morning (Saturday come to the facility The DON stated it w director of nursing, administrator, or so internal investigativ designated agency. The facility provided submission report t Health Facility Com investigative notes According to the re allegations were no allegation of physic been reported the of 4/25/15. There had allegation of verbal documentation indi- had been submitted report included LPN abuse of R65 howe witness accounts o and accounts from the CNP's assessmi indicated R65 had s However, nurses re area that was grabb altercation and CNI assessment comple had been swelling a The investigative re personal improvem	was notified of the abuse which occurred on 4/24/15 after stated staff had placed a his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, poial worker to submit any e reports to the State	F 225			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAR		ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	dementia training, f report to the board to another unit. During an interview 9:45 a.m., the DON counseling, educati behaviors especiall might become agita the DON stated the followed-up with LP incidents for R75 at employed by the fa- documentation as t was working on in r improvement, comp dementia related be personal stress in a abuse situations fro RN-A was interview she verified that LP Protocol training du received training or impaired residents incidents of alleged RN-A versified that had been required to related to Abuse Pr rights/Caring for the Following the surver reporting of these a verbal/physical abu the State agency (C abuse R75 had sus was made on 6/12/ plan of correction for	Follow up with social worker, of nursing, and reassignment with the DON on 6/12/15 at I stated LPN-E receiving ion on dealing with difficult y residents with dementia who ated and combative. However, e social worker who had PN-E after the alleged abuse nd R65 was no longer cility and there was no to what improvements LPN-E regards to his performance petence of handling agitated ehaviors, or dealing with a healthy manner to prevent om redeveloping. PN-E had received initial Abuse uring orientation, but had not in dealing with cognitively since hire until after the I abuse on 4/24/15. following the incidents, LPN-E to complete online education rohibition/Resident e Alzheimer's client on 4/28/15.	F 2	25			

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		AND HUMAN SERVICES				FORM	: 07/17/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245349	B. WING			06/	/17/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	situation existed. The the State agency in [Minnesota Departr to this writer's atten [LPN-E] was yelling was initially reporter another demented the main focus of the information in regar investigation of R65 was also agitated a responding to re-din at resident due to h [R75] and her contri initially combined be nurse [LPN-E] into a now reporting this p separate incident On 6/16/15 all staff facility's abuse proto from the assistant of reported for work. read the packet of i abuse protocol. The policies entitled: Baa Investigations, In-S Resident Abuse, Re Symptoms of Abuse Reporting/Investigation Agencies and Othe Reporting Suspecter Rape, Vulnerable A Misappropriation of Investigating Unexp	he incident description sent to cluded: "During routine MDH ment of Health], it was brought tion that on 4/24/15, staff LPN p at resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was nat OHFC report and rds to R75 was to support the 5. During this incident [R75] and following the nurse and not rection. Nurse [LPN-E] did yell is frustration with resident nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a ." received a copy of the ocol packet (forms undated) director of nursing as they The staff were requested to information in regards to be packet included specific to the section of Residents During ecognizing Signs and e/Neglect, ting Resident s. Abuse and/or Neglect oction of Residents During h, Report Abuse to State r Entities/Individuals, ed Cases and/or Incidents of dult Reporting of Alleged Residents Personal Property,	F2	225			

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		AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	In addition the pack undated facility poli- Life-Dignity, Employ Keys to Resident La and Indicators of Na Interviews were cor direct care staff, ac and supervisory nur shifts on 6/16/15 be p.m. to verify receip their shifts. Each st they had received a were in the process facility's IJ removal RN-A was interview RN-A stated all staff described as they m Facility policies rela- reviewed. An undat Reporting/Investiga Accidents/incidents reported to the direc- immediately to the a accidents/incidents thoroughly investiga findings of such inv by the Director of N An undated policy e Investigation includ abuse or neglect sh investigated."	ket of information included cies for Visitation, Quality of yee In-Service Program, Six oyalty, Indicators of Abuse, eglect. Inducted by survey staff with tivities staff, pool nursing staff, rsing from day and evening etween 2:20 p.m. and 2:40 of of education prior to starting aff person interviewed verified a packet of information and s of reading it as detailed in the plan. <i>ved</i> on 6/16/17 at 2:45 p.m If were provided training as eported to work. Atted to Abuse Prohibition were ted policy entitled tting Resident s included: "All involving residents must be ctor of nursing services and administratorAll involving residents will be atted by management and the restigation will be kept on file	F 22	5		

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		AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245349	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	substantiated incide immediately to the <i>A</i> reported to appropri- The immediate jeop was removed on 6/ determined the faci- plan for removal in as they reported to policies related to a and reporting prior residents. In addition been developed and complaince with face non-compliance removed Additional incidents policies for reporting The facility had sub- agency on 4/16/15, au indicated, "[R64] we next to [F-B]As he out of the chair, [F-I forearm" R64's diagnosis, ace admission record d with functional decli quarterly Minimum 3/25/15, identified F impairment and req from one person for (ADL)'s.	ents of abuse will be reported Administrator and promptly riate State agencies." pardy that began on 4/24/15, (16/15 when it could be ility had operationalized their regards to educating all staff work regarding the facility's abuse, neglect, maltreatment to allowing staff to work with on, montioring systems had id initiated to ensure continued cility protocols. However, mained.	F 22	5		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 20 FOURTH STREET NORTHEAST		
STEWAR	TVILLE CARE CENT	ΞR			TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	 4/15/15, included a observed resident a recliner chair. [F-B] back down. Nurse r voice. Nurse then o the chair control outhim on the right fore called social service Administrator notifie. Although the facility member striking R6 not reported to the day, 4/16/15. Although R99 susta origin on 8/19/14, th administrator and simmediately. An incident report for the State agency or had occurred the prwas found in her roassistant]. Another floor[R99] was staher left arm. She dia sent to the Emerged preliminary results i fracture of her left s R99's record was readmission record day impairment and required required and required the state agency or hard occurred the prwas found in her roassistant]. Another floor[R99] was staher left arm. She dia sent to the Emerged preliminary results i fracture of her left s 	note from 4:30 p.m., "Nurse attempting to get out of a attempted to tell resident to sit noted agitation in the [F-B ' s] bserved resident's [F-B] pull t of resident's hand and hit earmNurse immediately es to evaluate the situation. ed as well." was aware of the family 64 on 4/15/15, the incident was State agency until the next ained an injury of unknown he facility failed to ensure the tate agency were notified or R99 had been submitted to n 8/20/14 for an incident that revious day, "Res [resident] om by a CNA [certified nursing residentwas lying on the anding in the room guarding d complain of pain. Res was ncy Room for xray and indicate resident sustained a	F 2	25			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	07/17/2015 APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		245349	B. WING _	B. WING			7/2015
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		-	
STEWART	VILLE CARE CENTI	ER		120 FOURTH STREET NORTH STEWARTVILLE, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
	3/19/14 at 10:30 a.r resident's room and iriend was laying or was standing guard her left arm and sai was made to do RC A review of the facil nvestigation Repor administrator and d ndicated the incide administrator on "8/ reported to the Stat '8/20/14, PM." Although the facility of unknown origin of ensure the administrately The facility had sub agency on 8/12/14, cares [8/10/14] resi arge, purple-black forearm extending a ringer. Has no histo Resident is not able Alzheimer's disease R98's record was re admission record d. resident had diagno Alzheimer's disease 11/18/14, identified mpairment and was all activities of daily	sing progress notes dated m. included, "CNA entered this d noted that this resident's the floor and this resident ling her left armShe guards d owe-owe when any attempt DM [range of motion]." ity's Alleged Resident Abuse t Form, signed by the irector of nursing on 8/20/14, nt had been reported to the '20/14, AM," and had been e licensing agency on was aware R98 had bruising on 8/10/14, the facility failed to trator and state agency were /. mitted a report to the State which included: "During AM dent was discovered to have a bruise on the left medial along the left thumb and index ry of recent trauma, or falls. e to say what happened due to a." eviewed and the resident ated 12/5/08 indicated the bases including: dementia and and A quarterly MDS dated R98 had severe cognitive s totally dependent on staff for	F 22				

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ ⁻	17/2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	 8/10/14 at 12:40 p.r. cares were being p bruise was noted of extending along the measuring 23.5 cm 4.5 cm in width. The indicated R98's left edematous, and the as R98 cried out wh A Skin Integrity Ever indicated the purplismedial forearm extra and index finger, was swollen. A review of the facil Investigation Report the administrator at 8/15/14, included: "resident's L [left] metrauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impact intra-articular extension investigative report administrator had ministrator had ministrator. The administrator ministrator had ministrator. The administrator ministrator had ministrator. 	m., indicated while morning rovided, a large, purple-black n R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and e progress notes also hand and fingers were e area appeared to be tender, hen arm was moved. ents Report dated 8/10/14, sh-black bruise on R98's left ending to the side of the thumb as mildly painful and was lity's Alleged Resident Abuse rt Form, signed as reviewed by nd director of nursing on 'Unexplained bruise noted on edial forearm. No history of scomfort noted with gentle [nurse practitioner] on ordered. Results show a ted fracture distal radius with histon and osteoporosis" The also indicated the not been notified of the 8/10/14	F 2	25			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 07/17/2015 RM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
		245349	B. WING			06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225 F 226 SS=F	DON confirmed he to be submitted imm have a system prob Review of the facilit Abuse to State Age Entities/Individuals alleged/suspected v incident of mistreatu unknown source, or be immediately repo to proper State age 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle	te agency as required. The was aware the reports needed nediately and stated, "We dem." y's undated policy Reporting ncies and Other included: "Should an violation or substantiated ment, neglect, injuries of an r abuse be suspected, it must orted to the administrator and ncies." P/IMPLMENT ETC POLICIES velop and implement written		225		6/17/15	
	by: Based on interview facility failed to impl policies and proced reporting of alleged administrator and S resident/s from ong thorough investigati abuse/neglect for 5 R64, R99, R98) who prohibition. This had	NT is not met as evidenced and document review, the ement their abuse prohibition ures related to immediate abuse/neglect to the tate agency, protecting oing abuse, and completing a on following an allegation of of 26 residents (R75, R65, o were reviewed for abuse d the potential to affect all 68 residing in the facility.			Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusion set forth in the statement of deficiencies The facility has appealed the deficiencies and licensing violations stated herein. T Plan of Correction is prepared and/or executed as a means of continuously improve the quality of care, to comply w all applicable state and feral regulatory requirements and constitutes the facility allegation of compliance.	ns s. es ⁻ his <i>v</i> ith	

Facility ID: 00429

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		AND HUMAN SERVICES	1		OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245349	B. WING _		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
STEWAF	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 226	Continued From pa	ge 37	F 22	26		
	undated Policy and to Abuse Prohibition The undated policy and Symptoms of A personnel are to re- of abuse/neglect to director of nursing s the Administrator." and symptoms of a promptly. The proce physical abuse, sign and signs/symptom abuse/neglect. The undated policy Reporting/Investiga Accidents/Incidents involving residents of nursing services administrator." The "all accidents/incide thoroughly investigat findings of such inv by the Director of N The undated policy Investigation read, or neglect shall be p investigate the incid report daily to the a the investigation. T that employees that resident abuse would	entitled Recognizing Signs abuse/Neglect read, "all port any signs and symptoms their supervisor or to the services and immediately to The procedure directed signs buse should be reported edure lists signs of actual ns of actual physical neglect, is of psychological entitled ting Resident a read, "All accidents/incidents must be report to the director and immediately to the e procedure directed staff that ents involving residents will be ated by management and the estigation will be kept on file		Stewartville Care Center has of and implemented written polic procedures that prohibit mistre neglect, and abuse of resident p policies and procedures addre seven following components: a training, prevention, identificat investigation, protection, and reporting/response. Stewartville Care Center staff and respects each resident¿s free from maltreatment, negler misappropriation of property a that is within its control to prev occurrences. The facility staff residents who are at risk for al neglect, and/or misappropriatio property 2) develops interventi strategies to prevent occurren routinely reassesses the effect the interventions. During the mandatory staff tra 14, 15 and 16, 2015, the facilitit related to abuse prevention/ re were reviewed and the staff we instructed on 1) the types of incidents/accidents that need to immediately reported to the administrative/supervisory staff procedures for notifying the ad staff and the appropriate gove agencies of the incident/accide necessary documentation rela incidents/accidents.	ies and eatment, is and roperty. The ess the screening, ion, recognizes right to be ct, and nd does all ent such 1) identifies ouse, on of ion ces and 3) tiveness of ining July ry policies eporting ere to be ff 2) dministrative rnment ent and 3)	

Facility ID: 00429

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIP	PLE CONSTRUCTION	OMB NO. (X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245349	B. WING		06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226		-	F 226			
	the administrator.	tigation had been reviewed by		Resident number 75 ¿ The reside cognitive deficits and self-propels wheelchair around the facility. Sh	her	
		entitled Protection of		occasional negative interactions w		
		buse Investigation read, "Our esidents from harm during		residents which require staff inter		
		use allegations." The		She does not recall the incident fr 2015. The social worker will meet		
	procedure directed	that during abuse		resident weekly for four weeks an	d then	
		loyees accused of resident		monthly for six months to assess		
		assigned to nonresident care ve; and that if employees were		and behavior. The resident freque visits the Social Worker¿s office t		
		resident care duties, such		a piece of candy from the candy b		
		not be in any part of the		care plan was reviewed and found	b	
		esident frequents. The hould the results indicate that		appropriate.		
		propriate authorities will be		Resident number 65 ¿ The reside	ent	
	notified."			continues to wander throughout th		
	The undated policy	entitled Reporting Abuse to		floor of the facility. She has had n altercations with staff; her usual	o recent	
		Other Entities/Individuals		resistiveness to bathing continues	. The	
	read, "All alleged/su	uspected violations and all		resident has severe cognitive imp	airments	
		ents of abuse will be reported Administrator and promptly		and believes that she works at the and is a care taker for her grandp	,	
		iate state agencies. The		She does not recall the incident fr		
	procedure directed	"A. Should an		2015. The social worker frequent	y .	
		violation or substantiated		interacts with the resident as she		
		ment, neglect, injuries of r abuse to be suspected. It		the social service office several til day. The social worker will meet w		
		ly reported to the administrator		resident weekly for four weeks an		
		agencies 1. Olmsted County		monthly for six months to assess		
	Health/OHFC. B. \	Vinnesota Department of /erbal/written notices to the I be made immediately		and behavior. The care plan was and found appropriate.	reviewea	
		nt if possibleC. The		Residents number 64 ¿ The alleg	ed	
	administrator, or his	s/her designee, will submit		abuse by the resident is spouse w	vas	
		n report to OHFC website 5		observed 4/15/15 at 4:40 p.m. and		
	working days of the	e occurrence of the incident."		not reported to the State agency unnext day. The related facility polic		
	R75 was observed	to have been verbally abused		the regulatory requirements for in		

Facility ID: 00429

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245349	B. WING			06/1	17/2015
NAME OF	PROVIDER OR SUPPLIER		l	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	17/2013
STEWAF	TVILLE CARE CENT	ER		1	20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 226	by licensed practica The incident was madministrator or de was R75 protected thorough investigat A facility COMPLAI REGARDING an E completed by nursi The concern includ [LPN-E's first name CONCERN: Upon a residents from supp heard a lot of comm that the nurse [LPN at resident [R75]. V her room, she [R75] question and he sta That's when we rem situation" During an interview DON was asked fo immediate reporting administrator, OHF protect R75 from fu- residents and a tho abuse incident. Not stated he did not re- separately but was in regards to the ph DON stated he was abuse incident with physical abuse of R7 the evening meal a medications.	al nurse (LPN)-E on 4/24/15. ot immediately reported to the signated State agency, nor following this incident, or a	F 2	226	reporting were reviewed by the administrative and social service s continued quality improvement pur Resident number 99 ¿ The resider at the facility September 15, 2014. circumstances of the Alleged Resid Abuse Investigation Report Form f incident during the morning of Aug 2014 not being submitted until the afternoon was reviewed by the management staff for continuing q improvement purposes. Resident number 98 ¿ The resider at the facility December 29, 2014. circumstances regarding a bruise observed 8/10/14 and the 48-hour reporting the bruise to the administ and State agency were reviewed b management staff for continuing q improvement purposes. The Social Worker will monitor compliance by auditing incident rep timely and appropriate notification administrator and State agencies f next three months. If noncompliant noted, additional auditing and train be done. Compliance will be review during the September Quality Asse and Assurance Committee meeting ongoing.	poses. It died The dent or an ust 20, uality It died The delay in trator y the uality ports for of the or the ce is ing will ved essment	

		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF !	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	record until two day "Several staff mem conference room w voice towards resid indicated notificatio services, however of notifications were g The DON reported OHFC and to the C 6/12/15 after the su facility an immediat abuse existed. R65 had been verb LPN-E on 4/24/15 h immediately reported OHFC. The facility COMPL REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch her from behind like go over but [LPN-J] tried to calm reside she was too worked A typed witness acc that occurred on 4/2 investigation for R6 LPN-J read, "On Fr staff potluck,He [medication admin a grabbed the water pitch	 vs later on 4/27/15 and read, bers were in the south when a staff nurse heard raising lent." The progress note also on of DON, ADON, and Social did not indicate when the given. the verbal abuse of R75 to the common Entry Point (CEP) on urvey team had informed the te jeopardy (IJ) related to bally and physically abused by nowever, this was not ed to the administrator or LAINT/CONCERN FORM MPLOYEE completed by iso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to iso included. I attempted to iso included. 	F 2	26			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245349	B. WING _			06 / [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>			TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	on cart. She then ra him with it, not sure dropped it but it fell up and [R65] went a fist at which time I g [R65] to leave the a shortly after that." The facility provided submission report to of Health Facility Co investigative notes. complaint, the alleg to R65 had not bee had been reported R64 had an allegati family (F) member however, it was not until the next day. The facility submitte on 4/16/15 indicatin being hit on the fore around 4:40 p.m. "[chair next to [F-A] up and out of the ch forearm" A review of the nurs 4/15/15, at 4:30 p.n resident attempting [F-A] attempted to the Nurse noted agitation then observed reside right forearmNurs services to evaluate notified as well."	age 41 aised up her walker, as if to hit e if he knocked it down or she on the floor. [LPN-E] picked it as if to hit him with a closed got between them and asked area which she did. [LPN-E] left d the incident report, to the State agency (the Office omplaints-OHFC), and all . According to the OHFC gation of verbal/physical abuse en not immediately reported but the following day 4/25/15. ion of physical abuse by a which occurred on 4/15/15 t reported to the State agency ed a report to the State agency ng a nurse witnessed R64 earm by [F-A] on 4/15/15, [R64] was sitting in a reclining As he was attempting to get hair, [F-A] struck him on the sing progress notes, dated n., included, "Nurse observed to get out of a recliner chair. tell resident to sit back down. on in the [F-A]'s voice. Nurse dent's [F-A] pull the chair ent's hand and hit him on the se immediately called social e the situation. Administrator	F 22	226			

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CENTERS FOR MEDICARE & MEDICAID SERVICES	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
245349 B. WING	06/17/2015
	DRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	H STREET NORTHEAST VILLE, MN 55976
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BY FULL PREFIX (EACH DEFICIENCY BY FULL PREFIX (EACH DEFICIENCY MUST BY FULL PREFIX (EACH DEFICIENCY BY FULL PREF	PROVIDER'S PLAN OF CORRECTION (X5) ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 226 Continued From page 42 causing a fracture the facility did not immediately report the incident to the state agency. F 226 An incident report for R99, submitted to the State agency on 8/20/14 indicated, "Res [resident] was found in her room by a CNA [certified nursing assistant]. Another residentwas lying on the floor [R99] was standing in the room guarding her left arm. She did complain of pain. Res was sent to the Emergency Room for xray and preliminary results indicate resident sustained a fracture of her left shoulder" A review of the nursing progress notes dated 8/19/14 at 10:30 a.m., included: "CNA entered this resident's room and noted that this resident's friend was laying on the floor and this resident was standing guarding her left armShe guards her left arm and said owe-owe when any attempt was made to do ROM [range of motion]." A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/20/14, indicated the incident from 8/19/14 had first been reported to the administrator on "8/20/14, AM," and had subsequently been reported to the State Licensing Agency on "8/20/14, PM." R98 was found to have a large bruise on her left forearm which was found to be a fracture however, this was not immediately reported to the State agency or the administrator as directed by the facility abuse policy and procedure. The facility submitted a report to the state agency on 8/12/14, which included: "During AM cares [8/10/14] resident was discovered to have a large, purple-black bruise on the left medial forearm	DEFICIENCY)

Facility ID: 00429

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		INTED: 07/17/2015 FORM APPROVED //B NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)		(X3) DATE SURVEY COMPLETED
245349 B. V	WING	06/17/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG F TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
 F 226 Continued From page 43 extending along the left thumb and index finger. Has no history of recent trauma, or falls. Resident is not able to say what happened due to Alzheimer's Disease." A review of the nursing progress notes dated 8/10/14 at 12:40 p.m., indicated while morning cares were being provided, a large, purple-black bruise was noted on R98's left medial forearm, extending along the left thumb and index finger, measuring 23.5 cm (centimeters) in length, and 4.5 cm in width. Also included, R98's left hand and fingers were edematous, and the area appeared to be tender, as R98 cried out when arm was moved. A review of the facility's Alleged Resident Abuse Investigation Report Form, signed by the administrator and director of nursing on 8/15/14, included: "Unexplained bruise noted on residents L [left] medial forearm. No history of trauma to area. Discomfort noted with gentle ROM [range of motion]. Seen by NP [nurse practitioner] on 8-12-14, and x-ray ordered. Results show a comminuted impacted fracture distal radius with intra-articular extension and osteoporosis" Also included, the administrator was not notified until 8/12/14. Although the facility was aware R98 had bruising of unknown origin on 8/10/14, the facility failed to ensure the administrator and State agency were notified immediately. During interview on 6/11/15, at 9:34 a.m. the director of nursing (DON) indicated the administrative staff were to submit reports to the State agency and stated, "Other staff can, but I want them to call me." DON stated he carried a 		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245349 B. WING 06/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 VIMARY STATEMENT OF DEFICIENCIES			AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/17/2019 MAPPROVED D. 0938-039
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STEWARTVILLE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (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) CMM12TH DATE F 226 Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." F 247 F 247 7/27/15	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION (X3) D/	TE SURVEY
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 OEFICIENCY 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) (x6) COMPLETM TAG F 226 Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." F 247 F 247 SS=D ROOM/ROOMMATE CHANGE F 247			245349	B. WING		0	6/17/2015
STEWARTVILLE CARE CENTERSTEWARTVILLE, MN 55976(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLETN DATEF 226Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem."F 247F 2477/27/15F 247483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGEF 247F 2477/27/15	NAME OF F	PROVIDER OR SUPPLIER			ST	-	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLÉTM DATEF 226Continued From page 44 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem."F 247F 247F 2477/27/15F 247SS=DROOM/ROOMMATE CHANGEF 247F 247F 247F 247	STEWAR	TVILLE CARE CENTE	ER				
 cell phone and staff knew they could always reach him, and he would then report incidents to the administrator. DON verified the reports that were submitted for R64, R99, and R98, were not submitted immediately, as required, to the State agency and were not always reported immediately to the administrator. DON indicated he was aware the reports needed to be submitted immediately and stated, "We have a system problem." F 247 F 247 A83.15(e)(2) RIGHT TO NOTICE BEFORE F 247 ROOM/ROOMMATE CHANGE 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
the resident's room or roommate in the facility is changed.The staff at Stewartville Care Center respect the residents; right to receive notice of a new roommate for 2 of 2 residents (R11, R40) reviewed for admission, transfer, and discharge.The staff at Stewartville Care Center respect the residents; right to receive notice before the resident; s room or roommate is changed.Findings Include:The staff is sensitive to the trauma that a move or change of roommate causes some residents and attempt to be as accommodating as possible. The resident is asked about his/her preferences which are than taken into account when discussing changes of rooms or roommate after her family member (F)-Q died. R11 stated she knew she would have to get one, but was not told in advance of them coming. R11 also stated she was not told when her current roommate moved into their shared room.The staff at Stewartville Care Center respect the resident; s room or roommate is changed.R11's quarterly Minimum Data Set (MDS) dated 3/24/15 indicated R11 had intact cognition basedThe staff at Stewartville Care Center respect the residents; room or roommate saft her family member (F)-Q died. R11's quarterly Minimum Data Set (MDS) dated 3/24/15 indicated R11 had intact cognition based	F 247	cell phone and staff reach him, and he w the administrator. D were submitted for submitted immediat agency and were no immediately to the a he was aware the ro immediately and sta problem." 483.15(e)(2) RIGHT ROOM/ROOMMAT A resident has the r the resident's room changed. This REQUIREMEN by: Based on interview facility failed to prov roommate for 2 of 2 reviewed for admiss Findings Include: R11 was interviewe roommate safter he R11 stated she has roommate safter he R11 stated she was roommate moved in R11's quarterly Mini	f knew they could always would then report incidents to DON verified the reports that R64, R99, and R98, were not tely, as required, to the State of always reported administrator. DON indicated eports needed to be submitted ated, "We have a system T TO NOTICE BEFORE E CHANGE right to receive notice before or roommate in the facility is NT is not met as evidenced v and document review, the vide prior notice of a new 2 residents (R11, R40) sion, transfer, and discharge. d and asked about any on 6/09/2015 at 10:41 a.m. had several temporary er family member (F)-Q died. w she would have to get one, advance of them coming. R11 s not told when her current no their shared room. imum Data Set (MDS) dated			The staff at Stewartville Care Center respect the residents; right to receive notice before the resident; s room or roommate is changed. The staff is sensitive to the trauma that a move or change of roommate causes some residents and attempt to be as accommodating as possible. The resider is asked about his/her preferences which are than taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is moved at th facility; s request, an explanation of the reason for the move is provided. The	ıt

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		12 S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 247	Continued From pa	age 45	F 2	47			
	 F 247 Continued From page 45 on a score of fifteen on the brief interview for mental status (BIMS). R11's diagnoses included anemia, depression and diabetes mellitus. SS progress note dated 3/26/15 read, "Resident survey done recently and I followed up on concerns. R11 said that she was not informed of getting a new roommate after her [F-Q] died, which was some time ago. I apologized for that" On 6/09/2015 2:54 p.m. social services (SS)-A shared R11 had new roommates move into her shared room on 4/29/14, 7/24/14 and her current roommate moved in on 8/18/14. The SS-A verified she was unable to find documentation of new roommate notifications in the medical record for the above dates she received a new roommate. R40 was asked about roommate changes recently on 6/08/2015 at 6:58:56 p.m. R40 stated he had a new roommate move in two weeks ago and was not told in advance he would be getting a new roommate. R40's quarterly Minimum Data Set (MDS) dated 4/21/15 indicated R40 had intact cognition based on a score of fifteen on the BIMS. R40's diagnoses included Parkinson's disease and anemia. On 6/09/2015 2:54 p.m. SS-A verified R40 did have a recent roommate move into his shared room on 5/20/14. The SS-A verified she was unable to find documentation of a new roommate in R40's medical record. SS-A stated when a resident in the facility will be having a new roommate move in, the social service department documented a progress note in the 				 247 move, and meet the new roommate when possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another person into the room. On June 24, 2015, the facility¿s medical record consultant met with the social worker who started employment June 22, 2015 to discuss the required resident notifications including the resident¿s right to be informed prior to changes in rooms and roommates. A copy of the related regulations was provided for reference. The updated policy addressing new roommate notification was reviewed with the social service staff. The situation 		
					regarding lack of documentation verthat residents number 11 and 40 were notified of new roommates was als reviewed as part of the ongoing cone ducation and quality improvement procedures/process. The administrator will monitor complexely for four weeks through staff interview and record review verifying residents received notice prior to real new roommate. If noncompliance noted, additional monitoring and stattraining will be done. Compliance wereviewed at the September Quality	erifying ere o ntinuing pliance og that eceiving e is aff <i>i</i> ll be	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED	
		245349	B. WING _		06/	17/2015	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
STEWAF	TVILLE CARE CENTI	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 247	received notification roommate move in A facility policy was notification of havin a shared room, but	ge 46 record the resident had in they would be having a new to their shared room. requested on resident g a new roommate move in to was not received from the	F 24	47 Assessment and Assuranc quarterly meeting.	e Committee		
F 250 SS=D	RELATED SOCIAL The facility must pro	ovide medically-related social r maintain the highest I, mental, and psychosocial	F 25	50		7/27/15	
	by: Based on observat review the facility fa (R26) psychosocial reported ongoing co and neighbor reside and resulted in moor routines to avoid co had not had interve behaviors towards I Findings include: R26 was admitted t according to the fac R26's quarterly Min 4/15/15 indicated new was independent w During an interview	NT is not met as evidenced ion, interview, and record iled to ensure 1 of 1 resident needs were met when R26 oncerns with roommate (R68) ent (R1) that had not resolved dification of R26's daily onfrontation. Also R68 and R1 ntions developed in regards to R26. o the facility on 4/29/14 cility admission record. imum Data Set (MDS) dated o cognitive impairment and ith activities of daily living. on 6/9/15, at 8:26 a.m. in an tion "Have there been any		The Stewartville Care Cerr interdisciplinary team is co provide residents with com services to attain or mainta practicable physical, menta psychosocial well-being. T interdisciplinary team addr concerns with the goal to p supports, physical care, ar environment that meet the individual needs and prefe All residents are routinely a qualified staff, including a s assure they are effectively changes in health status, a facility, current family relati Medically-related social se	mmitted to prehensive ain their highest al and he ess residents; provide social id an enriched residents; rences. assessed by social worker, to coping with idmission to the onships, etc.		

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				יחוד	E CONSTRUCTION	MB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER		1: S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 250	Continued From pa	-	F 2	50			
	other resident," R26 to say that she had quarterly MDS date impairment) who liv shared the same ba to say that her room moderate cognitive quarterly MDS date yelled and cursed a over the past month door locked so she residents room to u occasions. R26 the daily told her when watch television, wh when and how to ge seemed to want mo for her things. In re- does that make you you what to do?" R bossy, I feel like I'm her, she's always te reported it to the so concerns, I'm not su is still hereI'm not my concerns. They less just got used to anything more." R2 very loud at night an stated she did not w had been treated (in	ns with a roommate or any 5 stated, "Yes.!" R26 went on problems with R1 (R1's d 4/8/15 shows no cognitive red in the adjacent room and athroom as R26. R26 went on nmate (R68 who had impairment according to the d 5/6/15). R26 stated R1 had ther on multiple occasions and kept R26's bathroom had to go into the other nlock it to use on several n said her roommate (R68) to go to bed, when she could here to put her walker, and et dressed. R26 stated R68 ore space in the shared room sponse to the question, "How a feel to have someone telling t26 stated, "She is kinda n walking on eggshells around elling me what to do. I've cial worker about the ure if the same social worker aware if she followed up with come and go fast. I more or o it, so I don't even say 6 further stated R68 snored nd kept her awake often. R26 vant to be treated the way she n reference to both R1 and expecting anything to change			 identified through completion of resassessment tools, quality indicator results, review of the medical historinformation from family/direct care and social service interviews/evalu. The staff follow up on situations/be that impact the resident;s psychos well-being; referrals are made to thattending physician or other clinical practitioners as indicated. The interdisciplinary team will review significant resident incidents, behavioral the quarterly care conferences. A nursing communication will be developed to alert the seconferences. A nursing communication will be developed to alert the seconferences and 16, 2015, the nursing staff of 1) oriented to use of the new communication tool and 2) reminded alert for and report any resident behaviors/conditions/statements ar family concerns that indicate need interventions to meet the resident; medically-related social service need. Resident number 26 - The social we met with the resident on June 10, 2 discuss her concerns regarding he 	report ry, staff, ations. haviors ocial e viors, ekly ation ocial ilitate ly 14, will be ed to be nd/or for s eds. orker 2015 to	
	help from the facility not to deal with it, h with it.	ad changed despite asking for y. R26 stated it would be nice owever had learned to deal nterview on 6/10/15, at. 1:30			roommate. The social worker noted ¿(resident) states she gets along f with roommate neither roomma wants to move or have the other roommate move out.¿ The residen	ine ite	

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TATEN.	RS FOR MEDICARE					0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245349	B. WING _		06/1	7/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
STEWAF	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 250	Continued From pa	ge 48	F 25	50			
1 230	well with problems y roommate (R68) ar me now It still hur frustrated, I'm not a to the question, "Ho stated, "When [R68 know what I did, bu dealt with the neigh a bedside commod confrontation with. I preferred to use the commode. R26 sta bit without one of th am doing." R26 sta change several mo worker had not eve stated, "I am tired nothing changes, s learned to deal with R26's care plan pro- read, "Has occasion her roommate and common bathroom support with is as n included interventio to resident and enc concerns and feelin explanation of diffic resolve the concern Social service prog "[R26] came to soci on 12/5/14 seeking other residents. Shi particularly cruel on	with neighbor (R1) and ad said, "I try not to let it bother ts my feelings, and I'm a child you know." In response bw do you deal with it?" R26 B] starts in, I just say "I don't t I'm sorry." R26 stated she bor bathroom issue by having e at night to avoid R26 stated she would e bathroom vs. the bed side ted, "I can't even move a little em questioning me on what I ated she had asked for a room nths ago, stated the social r come in to talk with her. R26 of reporting the concerns and o what's the point? I've just i.t." wided by the facility on 6/11/15 nal difficulties in dealing with others that she share a with but seeks out staff eeded. Care plan also n of "provide on-going support ourage resident to share her ng." The care plan lacked ulties and interventions to ns. ress note dated 12/5/14 read, ial work office late in the day support due to conflicts with e describes one resident being an ongoing basis and said ounded when her roommate,	F 25	 bathroom. The social worker resident on July 10, 2015. The note states, ¿Visited with ress regarding her roommate. She things have been `straightend that they are getting along to room. Resident reports that though she has enough room belongings. She also reports independently uses the commof the adjoining bathroom in night, and she is satisfied with arrangement. Resident reports satisfied with her current room not like to switch at this time. resident ¿s care plans of renumber 1 and number 65 had reviewed and updated to add regarding shared space. The visited by the social worker J and reported that ¿things are She declined an offer for a room. To monitor compliance, the F record consultant will random records twice monthly for two randomly thereafter for approdocumentation and follow up medically-related psychosoci noncompliance is noted, add auditing and staff training will Compliance will be reviewed September Quality Assessmet. 	e social work ident e reports that ed out;, and gether in the she feels as n for all of her that she node instead her room at h this ts that she is m and would ¿ The iewed and esidents ve been ress issues resident was uly 14, 2015 e going well.; bom change her current RN medical hly audit o months and opriate to al issues. If itional be done. during the		

Facility ID: 00429

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FORM MB NO. (X3) DATE	07/17/2015 APPROVED 0938-0391 E SURVEY PLETED
		245349	A. BUILDING B. WING				
		245549	B. WING			06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	∃R			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	for her. She is adjust avoid confrontation, place in the hallway with the supervisors pros and cons of a advised to speak w thoughts on the inter- place." The progress services would con- support and indicate social worker would R1's progress notes of follow-up perform R26 shared with so care plan read, "Do argumentative disp- residents. She has other" The care p confrontational with multiple room chan- reflect the issue wit R1. R68's progress note of follow-up perform R26. R68's care pla concerns, intervent roommate. R26's progress note monitoring had bee voiced concerns at further mention of the the resident brough again in her care co- Care conference pr read, "We provided about her interaction next door neighbor,	ars to be making things worse sting her bathroom routines to The comments also take ys and dining room. I spoke is about the situation and the room change and was ith roommate to ascertain her eractions reported to be taken is note further indicated social tinue to offer emotional ed if problem persisted the d attempt mediation. Is were reviewed, no evidence hed related to the concerns of cial worker on 12/5/14. R1's es present with an osition at times with other verbal behaviors toward lan also indicated she is residents and has had ges. The care plan did not h the shared bathroom with es were reviewed, no evidence hed related to the concerns of an did not reflect or identify any ions, or problems with es did not reflect follow-up or n performed as a result of the 12/5/15 meeting and no he issues until 4/29/15 when t the same concerns forward	F2	250			

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	OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONSTRUCTION). 0938-039 TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · · ·	MPLETED	
		245349	B. WING			/17/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
STEWAF	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 250	Continued From pa	ge 50 grown to better deal with them.	F 2	50			
	She tends to accon spoken up."	modate others but also has					
	medical record as a	vident in R26's, R1's, or R68's a result of the again mentioned as at the 4/29/15 care					
Du lice sta to		r on 6/9/15, at 3:30 p.m.					
	staff reported to he	ker (LSW) explained nursing r with any concerns pertaining d "every morning I see what is					
	aware of the conce	LSW stated she was not rns despite the concerns medical record. LSW stated					
	the facility had turn	ed over three social workers in stated the social worker who					
	LSW stated a griev	to that wing, left in May 2015. ance had not been filed.					
	director of nursing	on 6/9/15, at 4:00 p.m. (DON) stated a grievance had I stated a grievance should					
	have been filled ou with roommate (R6	t in regards to R26's concern 8) and neighbor (R1). Stated					
	roommate despite	vare of the problem with the the concerns documented in DON stated the concerns					
	should have been f his expectation wou	ollowed up on. DON indicated uld have been re-evaluation of					
	worker involvement	-					
	family member (F)-	on 6/10/15, at 2:08 p.m., A indicated awareness of hbor problems. Stated the					
	roommate had alwa telling [R26] what to	ays been complaining and o do, "[R68] tells her to turn the					
	things I hear it. [F thing, sarcastic thin	to bed, and where to put (68] is always saying smart gs to [R26]. [R26] says she en to her. She [R26] seems					

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		AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE	E SURVEY
		245349	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	STEWARTVILLE CARE CENTER			AA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED B. WING		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
F 250	really frustrated, ev Every time I call she her roommate. I ha [R26's] mood but I of stated had not been ongoing issues con neighbor. F-A expla R26, but had been handling the proble think [R26] is happy think she is happy. were not around sh of life. [R26] was ne know if she was up deal with it and dea a while before she want to create wave thing and mind her During an interview nursing assistant (N judgmental of peop R26's bathroom con the door so R26 ca NA-K further stated the roommate, "[R6 line [which divides r goand they have [R26] was shutting explained R26 was concerns, "she wou bad." NA-K explain resident concerns, social worker. During an interview licensed practical n not been aware of t roommate despite t	eryday there is something. e expresses frustration with ven't noticed a big change is do know she is frustrated." F-A n notified by the facility of the accrning the roommate or the ained had offered assistance to told by R26 she had been ms. To the question, "Do you y?" F-A stated, "No, I don't I would think if those people would have a better quality ever a person who let people set about something. She will al with it until it explodes, takes reports anything. She doesn't es, she wants to just do her				

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI		FORM MB NO.	07/17/2015 APPROVED 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		3		PLETED
		245349	B. WING			06 / [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER			05	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ĒR			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	commode had beer compromise to the During an interview NA-E stated "[R1] tr aggressiveshe ter a little more vulnera [R26] about the bat about letting people wants things a certa sideR26 will just a seen her get upset of person that holds tries to get along wi keeps to herself." I where R68 had atte down and had to be During an interview NA-A stated had wi R26 and R1 in the p of the problems with bathroom with R26. An undated policy of grievances/complaints r writing." "The admir responsibility of grie investigation to Soc a grievance and/or investigate the allegore report of such findir (5) working days of and/or complaint. An undated facility p Clinical Record rea Records of each re about personal and related to the reside	w about it." LPN-J stated a n placed in R26's as a bathroom problem with R1. on 6/11/15, at 3:13 p.m., ends to be more nds to pick on people that are ableshe really goes after hroomand is very vocal e know." NA-E stated, "[R68] ain way even if it's on [R26's] shrug it off and ignore it. I have and frustrated. She's the type is things in. She is the type that ith everyone, she is quiet and NA-E explained an example, empted to take R26's calendar e redirected. on 6/11/15, at 3:35 p.m., tnessed arguments between past. Stated everybody knew h R1 not wanting to share the	F2	250			

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					FORM A	PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		X3) DATE S COMPL	SURVEY
		245349	B. WING		06/17	7/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	-	(X5) COMPLETION DATE
F 250		N IDENTIFICATION NUMBER: A 245349 E SUPPLIER RECENTER MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) From page 53 cal record." 483.20(k)(1) DEVELOP HENSIVE CARE PLANS ust use the results of the assessment , review and revise the resident's nsive plan of care. Immust develop a comprehensive care ch resident that includes measurable and timetables to meet a resident's ursing, and mental and psychosocial are identified in the comprehensive nt. Idan must describe the services that are shed to attain or maintain the resident's acticable physical, mental, and ial well-being as required under nd any services that would otherwise d under §483.25 but are not provided resident's exercise of rights under ncluding the right to refuse treatment 3.10(b)(4). JIREMENT is not met as evidenced record review and interview, the facility evelop a comprehensive care plan for avior and psychotropic drug use for 1 nts (R45) who received psychotropic Is.	F 25	o		
F 279 SS=D	483.20(d), 483.20(k	x)(1) DEVELOP	F 27	9	7	7/17/15
		and revise the resident's				
	plan for each reside objectives and time medical, nursing, and	ent that includes measurable tables to meet a resident's nd mental and psychosocial				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment				
	by: Based on record refailed to develop a of mood, behavior and of 5 residents (R45) medications. Findings include: R45 was admitted to to the facility admised	eview and interview, the facility comprehensive care plan for d psychotropic drug use for 1) who received psychotropic o the facility 6/12/14 according sion record with diagnoses		Stewartville Care Center uses the re of the comprehensive assessment to develop, review and revise the reside comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetable meet the resident¿s needs as identif the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the	ent¿s es to fied in	

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Facility ID: 00429

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			()(0) N		OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245349	B. WING		06 /1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	-	;	STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
STEWAR		ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
		TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRE		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 279	Continued From pa	ae 54	F 279			
	R45's significant ch (MDS) dated 3/12/1 depression with a F interview) score of 9 bipolar disorder, an care rejection, and when compared to addition, the MDS i antipsychotic and a Care Area Assessm based off of the MD that required a plan as a result of the MD mood state, behavi psychotropic drug u R45's physician orc 6/10/15 included Le medication) 20 milli Wellbutrin XL (antic mg per day, Depak used as a mood stat day, and Zyprexa (a at bedtime. R45's care plan did included individualit the triggered care a and psychotropic di was identified; the c in regards to care a depression and ass	ange Minimum Data Set 5 indicated moderate PHQ-9 (resident mood 9, identified diagnosis of d indicated behavior status, wondering had worsened previous assessment. In ndicated R45 received ntidepressant medications. nent (CAA's) were triggered DS assessment information of care. The CAA's triggered DS assessment included: oral symptoms, and		resident¿s highest practicable mental, and psychosocial well- 3) recognizes the residents¿ ri- refuse cares/services. The care plan and MDS (minin set) related policies/procedures staff responsibilities for develo- revision of the comprehensive care were reviewed and revise seven days of completion of th comprehensive assessment, a interdisciplinary care plan is de During the mandatory meeting 14, 15, and 16, 2015, the licen- staff were 1) reminded of the fa policies for care plan implementation/reviews/update reminded that the residents¿ c must be current at all times an- instructed that care plans must the MDS triggered care areas f assessed as needing to be inc plan of care. The care plan for resident num reviewed and revised to more comprehensively address the t care areas of ¿behavioral sym ¿psychotropic drug use.¿ The	being and ght to num data s and the pment and plans of d. Within e n eveloped. s on June sed nursing acility es 2) are plans d 3) t address that are luded in the ober 45 was riggered ptoms; and	
	(LPN)-G verified the CAA's triggered by state, behavioral sy	censed practical nurse e care plan did not reflect the the MDS. LPN-G stated mood mptoms, and psychotropic ve been included in the care		¿mood state; was not triggere significant change MDS with a assessment reference date of 2015; the resident reported on symptoms indicative of depres	n June 10, ly two	
	plan. The facility policy N	linimum Data Set/Resident col/Care Planning that was not		As part of the quarterly care co process, the interdisciplinary te	onference	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/17/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
			_				
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
STEWAR	TVILLE CARE CENTI	ER					
					TEWARTVILLE, MN 55976	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From no						
F 2/9	Continued From pa	ige 55 ect current standards.	F 2	279	the agree plane for completeness		
		ect current standards.			the care plans for completeness, accuracy, and relevancy. For the ne	ext	
					quarter, the MDS Coordinator will c	onduct	
					focused audits on the care plans fo		
					residents who trigger the care areas behavior symptoms, mood state an		
					psychotropic drug use. If noncompl	iance	
					is noted, additional monitoring will b done. Compliance will be reviewed		
					the September Quality Assessment		
					Assurance Committee quarterly me	eting.	
F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA	0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	280			7/17/15
		ne right, unless adjudged					
	incompetent or othe incapacitated under	erwise found to be r the laws of the State, to					
	participate in planni	ing care and treatment or					
	changes in care an	d treatment.					
		are plan must be developed					
		the completion of the sessment; prepared by an					
		im, that includes the attending					
		red nurse with responsibility					
		d other appropriate staff in mined by the resident's needs,					
		practicable, the participation of					
	the resident, the res	sident's family or the resident's					
		e; and periodically reviewed am of qualified persons after					
	each assessment.	and of qualitied persons after					
		NT is not met as evidenced					
	by:						

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	T OF DEFICIENCIES		1		1	0938-039
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245349	B. WING		06/-	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWA	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 280	Based on observa review, the facility f care to include the for 1 of 1 resident (Findings include: R65 received hous supplement was gi amount consumed amount consumed to determine if ther in stabilizing weigh (RD)-B's progress staff to monitor inta monitoring food an indicated on the ca R65's care plan da able to feed self aff needs observing if needed." The liste provide setup for re apply condiments, An interview on 06, certified dietary ma wanders up and do weight this month, The nurses gave h times a day. No or she eats at a meal	tion, interview and document failed to revised the plan of dietician's recommendations (R65) reviewed. e supplement however, the ven to the resident but the was not documented and the of meals was not documented re was an effective intervention t loss. The registered dietician note dated 5/7/15, indicated ake; although, The need for d supplement intake was not	F 28	 Stewartville Care Center staff redevelop comprehensive care plaseven days after the completion comprehensive assessment. Care are prepared by an interdisciplin which includes the attending phyregistered nurse with responsibilit resident, and other appropriate as Professional disciplines work tog plan and provide necessary serve enhance the residents <i>j</i> function and quality of life. The residents family/legal representative are encouraged to participate in the planning process and care confect the greatest extent possible. Care routinely reviewed and revisiteam of qualified persons after equarterly assessment and more necessary. During mandatory meetings July and 16, 2015, the care staff will reinstructed on the facility is policare plan reviews and updates 2 informed of the regulatory require that the residents; care plans by communicating resider care/condition changes to the departmental supervisors, included of the regulatory regulation of the residents is the departmental supervisors, included of the regulatory resider care/condition changes to the departmental supervisors, included of the regulation of the residents is resident in the resident is resident in the resident in the resident in the resident is resident in the resident in the resident is resident in the resident is resident in the resident in the resident in the resident is resident in the resident in the resident in the resident is resident in the resident is resident in the resident in the resident in the resident is resident in the resident in the resident is resident	ans within of the ure plans ary team, vsician, a lity for the staff. gether to vices to al abilities and their care erences to re plans ed by a each often as (14, 15, be 1) icies for 2) rement e current he te care it ding the	
	 (RD)-B's progress staff to monitor intamonitoring food an indicated on the care plan da able to feed self affineeds observing if needed." The liste provide setup for reapply condiments, An interview on 06, certified dietary mawanders up and do weight this month, The nurses gave h times a day. No or she eats at a meal track now. An interview on 06, registered dietician 	note dated 5/7/15, indicated ake; although, The need for d supplement intake was not are plan. ted 2/2/15, indicated R65 "Is ter setup is provided and she is eating and assist as d approach is "One staff to each meal-open containers, cut foods and butter breads." /10/2015 at 12:32 a.m. with anager (CDM) who said R65 own the hallway. She lost currently she weighs 114 lbs. er a house supplement three ne keeps track of how much		 encouraged to participate in the planning process and care confect the greatest extent possible. Care are routinely reviewed and revisiteam of qualified persons after equarterly assessment and more necessary. During mandatory meetings July and 16, 2015, the care staff will reinstructed on the facility; s policare plan reviews and updates 2 informed of the regulatory require that the residents; care plans be at all times and 3) reminded of the importance of facilitating accura plans by communicating resider care/condition changes to the 	erences to re plans ed by a each often as (14, 15, be 1) icies for 2) rement e current he te care it ding the nanner. was tional	

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		245349	B. WING _		06/17/2015		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIO		
F 280	her weight loss is 1 "She is on the risk I months now." RD- looked at what the supplement. An interview on 06/ registered nurse (R house supplement one records how m A policy dated 4/20 "Nursing service	 past six months. As of today 1.6% for the past six months. list and being monitored for B continued to say I haven't nurses are signing out for her (11/2015, at 9:09 a.m. with three times a day but said no such is consumed. 00, entitled supplements read, record intake of supplement will be 	F 28	 supplement intake at meal time reviewed and found appropriate The care plan of resident number reflects the May 12, 2015 physic order for an increase in the nutris supplement from four ounces or day to three times per day due hweight loss related to increased expenditure from physical activit (continually walks throughout the of the facility). The nutrition care updated to include offering the r snacks and finger foods as the r walks about the facility. The resi weight will be monitored on a me basis and her supplement intake monitored on a daily basis. The resident currently weighs 11 pounds showing a slight weight past month. She weighed 105 p when admitted to the facility Apr 2013. After an initial weight gain pounds in 2013, she gained an a fifteen pounds last year after an period of reduced physical activit to non weight bearing status wh recovering from a fracture. After successful recovery and resump her usual physical activity, she is back to her September 1, 2013 weight of 114.0 pounds. The resident disting an or the physician/nurse practitioner consultant dietitian will be inform further weight loss. 	er 65 ian;s tional her est er recent calorie y e first floor plan was esident dent;s ponthly e will be 4.8 gain in the punds 1 30, of ten addition extended ty related le a btion of s now paseline ident;s ewed at eeded. and		

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		AND HUMAN SERVICES			FC	RM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245349	B. WING			06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ξ	(X5) COMPLETION DATE
F 280 F 309 SS=D	HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	CARE/SERVICES FOR	F 3		To monitor compliance, the dietary manager will audit the care plans of residents receiving nutritional supplements to assure that supplement are appropriately addressed. The dieta manager will monitor intake tracking of liquid supplements ordered for increase calories/protein weekly for four weeks a monthly thereafter. If noncompliance is noted, additional auditing and staff train will be done. Compliance will be review at the September Quality Assessment Assurance Committee quarterly meeting	ry ed and ning ved and	7/16/15
	by: Based on observat review, the facility f change in condition R2) with chronic pa Findings include: R11 was interviewe and stated she had shoulders. R11 stat	NT is not met as evidenced tion, interview and record ailed to reassess pain after a n for 2 of 2 residents (R11 & in. ed on 06/09/2015 at 10:26 a.m. l lots of pain in her back and ted she took a lot of pain d stated that she currently had			Stewartville Care Center provides eac resident with the necessary care and services to attain or maintain the highe practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. T interdisciplinary care team assesses ea resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident¿s condition indicates. The	st he	

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED		
		245349	B. WING _		06/*	17/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE			
STEWAR	RTVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 309	pain in the area tha (scale 0 no pain and she used Ultram (p she had "out-grown needed to have bot repaired, but did no 6/11/15 at 6:15 p.m her chair and eating shoulder pain was a nothing was being of R11 was admitted to diagnoses listed on included: chronic pa Physician orders of Ultram twice a day scheduled Tylenol e scheduled Narco (n times a day. On 3/18/15 the physion otherwise continues to her arthritis in he failed all conservation Assessment read,"of shoulder - quite sym The quarterly Minim R11 had a BIMS (bu of 15 or no cognitive R11 had rated her p assessment for pain The care area asse 7/9/14 indicated the at 10 in the shoulder received scheduled	t she would rate almost a 10 d 10 severe pain). Stated that ain medication), but felt that it." R11 stated that she h rotator cuffs (shoulders) t want surgery again. On . R11 was observed sitting in g her meal. R11 stated her at a 10 out of 10 and that done for her. o the facility in 2006 and had the physician orders that ain and osteoarthrosis. 6/11/15 included: scheduled and as needed (PRN), extra strength twice a day, harcotic medication) three sician note read, "Patient s to have symptoms in regards r shoulders. Patient also has ve therapies for that." degenerative joint disease -	F 3	 resident¿s condition and reffective pain managemen When a resident experient of care is developed, implication of the panalgesic orders and contrassessments. In April 2015, the facility rerevised the pain assessments. In April 2015, the facility rerevised the pain assessments of precipitating factors for papharmacological and nonprinterventions and their effec of the Comprehensive Pa Form to evaluate the reside pain, type of pain, causes interventions to alleviate presidents who flagged the indicator on the MDS 3.0 Quality Measure Report with Pain Flow Sheet and the Comprehensive Assessment, the pair plan will be reassessed. The physician/nurse practition of regarding ongoing pain sy care plan will be revised a reflect current pharmacological intervalleviate pain. During the mandatory me 15, and 16, 2015, the nurse reminded 1) to be alert to the fact of the section. 	nt are evaluated. ces pain, a plan emented, revised as hysician;s inuing eviewed and ent policies and a Pain Flow ation, intensity, in as well as oharmacological ectiveness and in Assessment dent;s history of of pain, and pain quality Resident Level vere first to have he ent Form ings from the n management he er will be notified rmptoms. The is necessary to ogical and ventions to etings, July 14, sing staff will be			

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				T/01			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · /	E SURVEY PLETED
		245349	B. WING			06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 60	F 3	309			
		x [symptoms] of pain limiting			tracking forms. The MDS Coordina continue to initiate the pain flow she and complete pain assessments for	eets	
	dated 3/23/15 noted pain, that made it h the pain at a 8 out o				residents flagging the pain indicato Resident Level Quality Measure Re and for residents who report a sign increase in pain or have uncontrolle	r on the eport ificant ed pain.	
		During an interview on 6/11/15 at 6:24 p.m. licensed practical nurse (LPN)-J stated R11			The physician/nurse practitioner wi notified and reassessments will be as indicated.		
	usually had pain an wanted her to have The facility would a LPN-J stated she th	ad that the physician only pain medications for control. Iso provide warm packs. hought the pain was related to wels) in the abdomen and that			Resident number 2 ¿ A 5-day pain tracking tool has been initiated to h identify pain frequency, location, in and effectiveness of interventions. reassessment of the pain manager	tensity A	
	the facility could us pills.	e a rectal tube and anti-gas			plan will be done after a review of t collected data, resident/staff interv and review of the nurses and	he views,	
	regards to a pain as stated that she was assessments and a in the hard copy ch	on 6/11/15 at 11:30 a.m. in ssessment for R11, RN-F s just starting to do pain any pain assessment would be art. However, none was			physician/nurse practitioner progre notes. (The physician was called Ju 2015 regarding uncontrolled pain a visit is scheduled for June 14, 2015	uly 7, Ind a 5).	
	located nor provide R2 was interviewed	d when requested. d on 6/8/15 at 6:29 p.m. and			During the June 23, 2015 MDS pai interview, the resident indicated he was a ¿ten¿ on a ten-point intensit	r pain	
	stated that her legs her bottom was sor of the Hoyer mecha	ached. R2 also stated that re because of cancer and use anical lift. R2 stated her pain ut of 10 scale, but currently did			but stated her pain did not impact her sleep or day-to-day activities. Evalu of the resident is pain and the effectiveness of the interventions we ongoing. The care plan will continue	ner uation vill be	
	The care conference indicated R2 stated	ce on 4/7/15 documentation I she was having more pain			updated to reflect the resident; s pa symptoms and interventions.	ain	
		ntation of 4/20/15 noted right Illing for R2. The nursing			Resident number 11 ¿ A 5-day pair tracking tool has been initiated to h identify pain frequency, location, in and effectiveness of interventions.	ielp tensity	

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		AND HUMAN SERVICES			FORM /	07/17/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED	
		245349	B. WING		06/17/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309 F 323 SS=E	document the resid The annual MDS da BIMS of 14 or no co section was left und dated 3/24/15 indic scale of 10. R2's care plan date had pain due to god in back and should On 06/11/2015 at 1 coordinator, stated pain assessments a yet. The facility's undate Pain Evaluation Pro pain was to be reas condition indicates On 06/11/2015 at 1 nursing stated he w assessments be co assessments had r 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	 20/15 through 6/11/15 did not lent having pain. ated 12/23/14 indicated a ognitive impairment, the pain done. The quarterly MDS ated a pain intensity of 7 on a ated 4/6/15 indicate the resident ut and generalized pain usually ers. 11:30 a.m. RN-F, the MDS that she was just starting to do and had not done any for R2 ated policy entitled Resident blocol directed the resident's seessed quarterly and when the need. 2:03 p.m. the director of would expect pain ompleted and that he knew the not been done for R2. F ACCIDENT 	F 30	9 reassessment of the pain managem plan will be done after a review of the collected data, resident/staff intervie and a review of the nurses; and physician/nurse practitioner progres notes (a physician visit is scheduled June 14, 2015). The June 9, 2015 starvice note states, ; reports that he mood is improving and she is startin feel better.; The July 10, 2015 nurse note states, ;No complaint of pain of evening shift.; The pain manageme plan of care will be reviewed and up as necessary. Evaluation of the resident; s pain and the effectiveness the interventions will be ongoing. Compliance will be monitored by the Assistant Director of Nurses/Design auditing for pain assessments for residents flagging the indicator mean pain on the Monthly Resident Level Quality Measure Report for three mod f noncompliance is noted, additionat auditing and staff training will be dor Compliance will be reviewed at the September Quality Assessment and Assurance Committee quarterly mean	ne ews, ss d for social er ng to se is potated ss of ss of enee by asuring onths. al ne. d eting.	7/17/15	
		on and assistance devices to					

Facility ID: 00429

If continuation sheet Page 62 of 97

		AND HUMAN SERVICES			FOR	D: 07/17/2015 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			()	ATE SURVEY OMPLETED
		245349	B. WING		0	6/17/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From pa	ige 62	F	323		
	by: Based on observative review, the facility fall risk following m (R73) reviewed for to ensure a safe en hazards in the facilit R46, R26) reviewed Findings include: R73 was observed in his wheelchair at shoulders rounded table. At 5:27 p.m. independently whee table using his feet foot rests were in the using his feet in bet The quarterly Minin 3/3/15 was reviewe interview of mental loss, no history of re assist with bed mot limit assistance with of traumatic brain in The incident report 5/19/15 at 6:10 p.m R73 on his knees a the chair. No injurin notes of 5/20/15 inconeeds of waiting for	on 6/8/15 at 5:22 p.m. sitting the dining room table with his and leaning forward to the R73 was observed to el the chair away from the on the floor. The wheelchair ne down position with R73 tween the foot rests. num Data Set (MDS) dated d. R73 had a BIMS (brief status) of 12 or mild cognitive ecent falls, required extensive pility and transfer, required h mobility, and had a diagnosis			Stewartville Care Center has policies an procedures to ensure that the residents; environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develop a plan of care addressing safety issues with interventions to enhance mobility an promote safety. The policies and procedures related to assessing the resident;s risk of falls were reviewed and found appropriate. An assessment of fall risk will continue to be done at the time of admission. A reassessment will be done as part the quarterly interdisciplinary assessment process and whenever there is a change in the resident;s behavior, physical condition, and/or mental function. The resident;s care plan is modified as necessary to ensure maximum safety ar minimal risk of injury. During the mandatory meetings July 14, 15, and 16, 2015, the licensed nurses ar direct care staff were reinstructed on 1) the importance of providing a safe environment for residents 2) the procedures for completing the fall risk assessments and 3) the need to assess the resident;s need for safety	os d re a d

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		AND HUMAN SERVICES			FORM	07/17/2019 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245349	B. WING		06/-	17/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 63	F3	23		
	6:;26 p.m. R73 was his wheelchair into is independent in the wife at assisted livin effective. He is aler ability to take the pi placed next to reside attempts of residen his wheelchair. The facility had con 4/10/15 at 9:06 a.m assistant had heard room, and found the the bed. The reside bed. R73 reported injury found. No fur were found. The resident's care was a fall risk and t normal risk for falls resulting in hip fract impaired cognition. on floor for safety a transfers. Fall Risk Evaluation Assessment were of 2/11/15 were found scored a 17 or mod	dated 8/14/15, 11/11/14, in the chart. All assessments lerate risk for falls.		 interventions/devices and routinel evaluate their effectiveness. All the nonskid safety strips have been in and either removed or replaced. The environmental Director will include monitoring of the condition of floononskid safety strips as part of the safety inspection process. Resident number 73 - The resider and history of falls were reassess to the resident a process (related to a history of falls were reassess to the resident a physical therapy reference ataxic gait) a physical therapy reference. After therapy goals are menursing restorative program will b implemented to maintain strength ambulation abilities and reduce the falls. The care plan was reviewed updated accordingly. Resident number 68 and reduce the falls. The care plan was reviewed updated accordingly. Resident number 68 been installed. Resident number 46 and the resident and the process. 	e floor ispected he e r e r outine ht is risk ed. Due in falls story of hip with erral was t, a e and e risk of and floor sed; ed in strips floor sed.	
	6/11/15 at 3:15 p.m had told her that no call light on and tha	PT)-A was interviewed on . to discuss the fall risk. He o one came in when he put the it he required assist with all ed R73 was last seen by		nonskid safety strips was reasses The strips were removed. The Director of Nurses/designee monitor compliance with post-fall		

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	DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED	
		245349	B. WING _		06/	17/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
STEWA	RTVILLE CARE CENTI	ER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 323	therapy in May 2015 been notified of furt R73 was at a high f impulsiveness, histo history of TBI that a that R73 could work balance safety and needed contact gua control. The director of nurs 6/11/15 at 5:28 p.m probably be reasse determine the caus physical therapy bu for need. LACK OF SECURE PREVENT SLIPPIN During an environm at 10:14 a.m. with r the following was of R68's room had am originally stuck to th were loose and fray the middle of the re front of the resident trip hazard and agro removed and said, he preceded to rem the floor. R68's care plan dat greater than norma diagnosis of dizzine	4. PT-A stated she had not her falls. PT-A added that all risk related to his ory of hip fracture and medical ffects his balance. PT-A felt with physical therapy for sequency. PT-A stated R73 ard and lacked impulse sing (DON) was interviewed on . and stated R73 should ssed following the falls to e. DON added R73 could use t needed to first be assessed ED SAFETY STRIPS TO IG: mental facility tour on 06/11/15, naintenance manager (MM)-A	F 32	assessments through reco weekly for four weeks. If no noted, additional monitorin education will be done. Co reviewed at the September Assessment and Assurance quarterly meeting.	oncompliance is g and staff mpliance will be ^r Quality		

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	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245349	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER		20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 323	Continued From pa it is free from hazar obstacles, items on R46's room had no floor which were cu located in front of h agreed they were a R46's care plan dat "comprehensive a than normal risk for increasing her fall r the care plan read, make sure it is free lighting, obstacles, R26's room had thr attached to the floo about two feet in fro and the ends of the curling up. MM-A a hazard. R26's care plan dat "comprehensive a than normal risk for failure and use of d approach listed on the environment to hazards such as po on the floor" On 06/11/15, at 10: ago he did a safety document his findin	age 65 rds such as poor lighting, in the floor" on slip strips adhered to her urling up around the edges her recliner. MM-A again a trip hazard. ted 5/12/15, read, assessment reveals a greater r falls is on an antipsychotic risk." The approach listed on "Review the environment to e from hazards such as poor items on the floor" ree non skid strips which were or in the middle of the room ont of the bed. The middle ese strips were loose and again agreed they were a trip	F 323	DEFICIENCY)	HIAIE	
	during these inspec					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/17/2015 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245349	B. WING		06/17/2015			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
STEWAR	TVILLE CARE CENTE	ĒR	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 323	director of nursing (there is any docume but did agree the pe be removed.	ge 66 DON) said he was not aware entation of safety inspections eeling non slip strips need to requested but not received.	F 323					
F 325 SS=D	UNLESS UNAVOID Based on a residen assessment, the fac resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t (2) Receives a thera nutritional problem.	t's comprehensive cility must ensure that a stable parameters of nutritional y weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a	F 325			7/17/15		
	by: Based on observat review, the facility fa reassess nutritiona (R65) reviewed for Findings include: R65 had a significat 180 days however, were not monitored maintain or gain we R65 received house	nt weight loss over the past interventions put in place /assessed if appropriate to		Based on a resident; s comprehen assessment, Stewartville Care Cen ensures that a resident maintains acceptable parameters of nutritiona status, such as body weight and pro- levels, unless the resident; s clinical condition demonstrates that this is a possible. Therapeutic diets are pro- as ordered by the physician. The Nutritional Care Plan Policy wa reviewed and revised. The Nutrition Supplement Policy was updated to address tracking the amount of	ter al otein al not vided			

Facility ID: 00429

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
		IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	FLEIED
		245349	B. WING			17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
STEWAF	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 325	Continued From pa	age 67	F 32	5		
	actual amount cons and the amount con documented to dete effective intervention R65's most recent progress note date reflected weight loss past 30 days, six por and 16 pounds (12) Weight loss is signip progress notes autil dietician (RD)-B da resident's current w weight six months a weight loss of 9.2 p Recommended how to four ounces three further weight loss monitor intake. R65 was admitted weight loss monitor intake.	sumed was not documented nsumed of meals was not ermine if there was an on in stabilizing weight loss. weight from dietary resident d 6/10/2015, was 114 pounds as of four pounds (3.4 percent) ounds (5 percent) past 90 days .3 percent) past 180 days. ificant past 180 days. Dietary hored by the registered ted 5/7/15, indicated veight is 118 pounds and ago, 130 pounds. This reflects bercent in 6 months. use supplement be increased e times a day to prevent was initiated and staff to with diagnoses that included (cerebral vascular accident). m Data Set (MDS) dated R65 required supervision for lso indicated R65 had no ghing/choking during meals or ult chewing or swallowing. The MDS dated 1/28/15, R65 n, oversight, encouragement eal time. R65's weight was time.	Γ 32	 supplement consumed other time. A designated space with the medication administrati (MAR) to document the am supplement consumed. The tracking supplement intake was reviewed and found ap. The staff will continue to as residents ¿ condition, include needs/risks upon admission significant change occurs, at than once every three monthe (re)assessments, a complan of care is developed the the resident ¿s nutritional needs/risk and revised as need the resident and procedure and monitoring weights have reviewed and found approprime and monitoring weights have reviewed and found approprime as ordered by the phy requested by the dietitian on nurse. If the resident has have nontherapeutic weight charrisk of weight loss, the resident and 16, 2015, the licensed instructed on the changes i related to recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of recording the am supplement consumed on the nursing assistants will be relimportance of re	vas added to on record ount of e procedure for at meal time opropriate. sess the ling nutritional n, when a and no less ths. Based on nprehensive nat addresses eeds and riewed at least cessary. es for recording ve been oriate. nthly and more vsician or as r licensed ad nges or is at dent;s sed and the nsultant s July 14, 15, nurses will be n procedures ount of the MAR. The eminded of the	

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		AND HUMAN SERVICES			OŅ		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245349	B. WING			06 /1	7/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 325	offered food, fluic No other mention of available nor was a Medication flow she until 6/10/15, indication house supplement consumed. The mu until 5/31/15, indication supplement with th 6/1/15. Monthly we sheet during this per A dietary nutritional indicated no concernutritional assessme time. Computer generater received from certifive weight on 1/5/15, 1 lbs; 3/1/15, 120.4 I 118.4 lbs; 6/1/15, 1 Observations on 6/ 75% of her meal. ate 50% of meal. An interview on 06/ CDM who said R65 hallway. She lost w	ndering up and down halls. Is and activity as appropriate." of food consumed was iny provided when requested. eets reviewed from 3/1/15, ate R65 given four ounces of but no monitoring of amount edication flow sheet for 3/1/15, ate once a day house ree times a day started on eights also listed on medication eriod. assessment dated 1/28/15, rns at that time and no further tied dietary manager (CDM), 27.8 pounds (lbs); 2/2/15, 124 bs; 4/1/15, 120 lbs; 5/1/15, 14 lbs. 10/15, at 12:06 p.m. R65 ate On 6/11/15, at 12:03 p.m. R65	F 3	325		sheet. 5 25 3al per recent orie st floor an was dent dent dt;s nly ll be n in the ds), ten ended elated n of ow	
	hallway. She lost weight this month, currently she weighs 114 lbs. The nurses give her a house supplement three times a day. However, no one keeps track of how much she eats at a meal but they will start keeping track now. An interview on 06/11/2015, on 8:48 a.m. RD-B said R65 consumes her meals well and takes a					eline nt¿s ed at ed. d	

Facility ID: 00429

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245349	B. WING			06 /-	17/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWA	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 325	energy by walking had a weight loss of As of today her we six months. "She is monitored for mon at what the nurses nutritional supplement An interview on 06, registered nurse (F house supplement does not measures anyone record how An interview with F 9:14 a.m. both said much supplement validated they can treatment when it is An interview on 06, director of nurses (expectation is the of of the meal R65 e monitor how much her supplement when R65's care plan da feed self after setu observing if she is The listed approac for reach meal-ope condiments, cut for A undated policy en preventing ongoing residents in the fact	 imes a day. She expels a lot of so much. In May 2015, she of 9.2% for the past six months. ight loss is 11.6% for the past s on the risk list and being ths now" and I haven't looked are signing out for her nent. /11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said s how much is given nor does a much is consumed by R65. RD and CDM on 06/11/2015, at d they have not assessed how the resident consumes. They not assess effectiveness of the 	F 3	25	To monitor compliance, the dietary manager will audit the care plans or residents receiving nutritional supplements to assure that supple are appropriately addressed. The of manager will also monitor intake tra- of liquid supplements ordered for increased calories/protein weekly f weeks and monthly thereafter. If noncompliance is noted, additional auditing and staff training will be do Compliance will be reviewed at the September Quality Assessment an Assurance Committee quarterly mo	ments lietary acking or four one.	

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245349	B. WING			06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 F 431 SS=E	Continued From pa for two month, they and risk intervention A policy dated 4/200 nutritional risk read, following conditions Nutritional risk: Low caloric and/or nutrie condition." A policy dated 4/200 "Nursing service r and "Need for an in monitored by nursin 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in s accurate reconciliat records are in order controlled drugs is r reconciled. Drugs and biological labeled in accordan professional princip appropriate accesso instructions, and the applicable. In accordance with facility must store a locked compartmer	age 70 will be addressed as a risk ns will begin." 00, entitled residents at , "Residents with any of the s should be considered at y body weight and increased ent needs related to medical 00, entitled supplements read, record intake of supplement" take of supplement will be ng personnel." DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the III drugs and biologicals in nts under proper temperature	n	325			7/17/15
	have access to the	t only authorized personnel to keys.					

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	-	AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES				E CONSTRUCTION		0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ECONSTRUCTION		SURVEY PLETED
			/				
		245349	B. WING			06/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	B			20 FOURTH STREET NORTHEAST		
_				S	TEWARTVILLE, MN 55976		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	~	CROSS-REFERENCED TO THE APPROPF		DATE
					DEFICIENCY)		
F 431		74		~ 1			
F 431	Continued From pa	ge / I	F 4	31			
	The facility must pro	ovide separately locked,					
		compartments for storage of					
	controlled drugs list	ed in Schedule II of the					
		ug Abuse Prevention and					
		and other drugs subject to the facility uses single unit					
		bution systems in which the					
		inimal and a missing dose can					
	be readily detected.	- -					
	This REQUIREMEN	NT is not met as evidenced					
	by:						
		and document review, the			Stewartville Care Center provides		
		ure safe and secure disposal			pharmaceutical services to meet the needs of each resident. The facility	е	
		ppical narcotic analgesic s according to currently			contracts with a licensed consultant	ł	
		to prevent potential diversion			pharmacist who collaborates with fa		
	for 2 of 2 residents	(R7 & R55) reviewed with			staff to coordinate pharmaceutical	-	
		I patches. Also medications			services and guide the development		
		were not removed to prevent medications opened lacked			implementation of related procedure		
		nine when it would be			ensure the accurate acquiring, rece dispensing, storing and administeri		
		e potential to affect several			all drugs and biologicals. The pharr		
	residents including	(R29, R4, R65, R42, R46,			has established a system of records	s of	
		tilized stock medications and			receipt and disposition of all control		
	prescription medica	luons.			drugs in sufficient detail to enable a accurate reconciliation and determi		
	Findings include:				that drug records are in order and the		
	-				account of all controlled drugs is		
		ord dated 4/9/10, indicated			maintained and periodically reconci	led.	
		lumbago and abnormal			Drugo and biologicals are labeled in		
	sensation with pain	in the left leg.			Drugs and biologicals are labeled in accordance with currently accepted		
	R7's physician orde	rs dated 5/14/15, included an			professional principles, and include		
	order for Fentanyl p	atch 25 micrograms (mcg) to			appropriate instructions and expirat	ion	
		mally (to the skin) every 72			dates when applicable. In accordan		

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI T	TIPLE	CONSTRUCTION	MB NO. 0938-03 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED
		245349	B. WING _			06/17/2015
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
STEWAF	TVILLE CARE CENT	ER) FOURTH STREET NORTHEAST EWARTVILLE, MN 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
F 431	Continued From pa	ige 72	F 43	31		
	and change patch of pain. **When remo- and flush down toile R7's Fentanyl patch and stored in the W R55's admission re diagnosis including R55's physician orco- order for Fentanyl p transdermally every instruction, "When tissue and flush dor container.**" R55's administered from a medication cart. During an interview trained medical ass policy when removi patches, was for tw destruction by putti container attached	instructions, "Apply 1 patch q [every] 72 h [hours] for back ving old patch, wrap in tissue et or put in sharps container.**" hes were administered from /est medication cart. cord dated 7/27/11, indicated generalized pain. ders dated 4/7/15, included an batch 50 mcg to be applied y 72 hours, with special removing old patch, wrap in wn toilet or put in sharps Fentanyl patches were and stored in the North y on 6/8/15, at 7:15 p.m., sistant (TMA)-A indicated the ng and disposing of Fentanyl yo staff to witness the ng them in the sharps to the medication cart, and for a Medication Administration			State and Federal laws, all drugs a biologicals are stored in locked compartments under proper temper controls. The facility provides separ locked and permanently affixed compartments for storage of contro- drugs. The facility utilizes only pers- authorized under state requirement administer medications and have a to medication room keys/security of Outdated and expired drugs and biologicals are routinely discarded according to accepted practice sta The procedure for disposing of cor- substances was reviewed and revi Fentanyl patches will now be wrap tissue and flushed into the sewer s in the presence of two nurses. All medication storage areas were checked for discontinued and unlabeled/undated/expired medica and biologicals. The doors securin sharps containers were inspected; were found in good order with a fur locking mechanism. Any problems	erature rately olled sons ts to access odes. ndards. htrolled sed; all ped in system tions g the all nctional
	medication adminis medication cart, the container attached unlocked and could the content in the s container was easil compartment by sli from the cart. The o several pieces of o	ion on 6/10/15, at 8:40 a.m., of stration from the West e locking door on the sharps to the cart was observed to be d easily be opened, exposing harps container. The sharps ly removed from the ding it forward and removing door to the compartment had ld tape on the front and ape on the right side of the			the function/condition of the doors reported to Weber and Judd Pharr who owns the carts. During the mandatory meetings Ju 15, and 17, 2015, the licensed nur- trained medication assistants were reinstructed on the procedures for processing discontinued and outda medications and biologicals included destruction of used Fentynal patch reminded that the doors securing t	nacy ly 14, ses and 1) ated ing the es 2)

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO.	<u>0938-038</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245349			06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTE	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 431	at 8:50 a.m., the Ea container compartm unlocked and could the sharps container easily removed from forward. Licensed p the door was unlock could be removed. During a review of r at 8:55 a.m., the No container compartm unlocked and could the sharps container easily removed from forward. Registered door was unlocked could be removed. During a review of r at 9:10 a.m., the low sharps container co be unlocked and co exposing the sharps container was easily compartment by slid the door was unlock should be locked." During an interview LPN-B stated when from the residents f two staff to witness	nedication storage on 6/10/15, ast medication cart sharps nent door, was noted to be easily be opened, exposing er. The sharps container was in the compartment by sliding it practical nurse (LPN)-A verified ked and the sharps container medication storage on 6/10/15, orth medication cart sharps nent door, was noted to be easily be opened, exposing er. The sharps container was in the compartment by sliding it I nurse (RN)-B verified the and the sharps container medication storage on 6/10/15, ver level medication cart ompartment door was noted to uld easily be opened, s container. The sharps y removed from the ding it forward. LPN-L verified ked and stated, "The door on 6/10/15, at 9:15 a.m., removing Fentanyl patches or disposal , the policy was for the destruction of the patch, e patch in the sewer system	F 43	1 sharps container should be lock times 3) that multiple dose medivials must be dated when first urefrigerator temperatures must be monitored and recorded on the designated sheet. To monitor compliance, a licens nurse/trained medication aide withe medication storage areas micheck for undated/expired/outdated medications and biologicals and monitoring of refrigerator temperations of refrigerator temperations of the consultant pharmacist will consultant pharmacist will consultated/unlabeled/outdated medication will be reviewed dures September Quality Assessment Assurance Committee quarterly and ongoing.	cation sed and 4) be ed ill audit onthly to ited ratures. ontinue to peratures edications. ring the and	

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						FORM	APPROVED 0938-0391
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 245349 NAME OF PROVIDER OR SUPPLIER STEWARTVILLE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 Continued From page 74 sharps container," pointing to the sharps container attached to the side of the West medication cart. When asked about the door to the sharps container compartment being unlocked and the ease of removing the sharps container, LPN-B verified the door was unlocked and attempted to use a key to lock it, but was		` '			(X3) DATE	E SURVEY PLETED	
		245349	B. WING	i		06/ [.]	17/2015
NAME OF	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
STEWAE	RTVILLE CARE CENT	FR			120 FOURTH STREET NORTHEAST		
0121171				!	STEWARTVILLE, MN 55976		
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	sharps container," p container attached medication cart. Wh the sharps container unlocked and the ex- container, LPN-B ve and attempted to us unable to get it lock fits, but doesn't turn During an interview director of nursing (that the sharps com- found to be unlocked stated, "They shoul- unlocked doors on sharps containers, a containers where us disposed, and this h DON indicated he v for the West medica was cracked, and the A policy was request secure disposal of h provided. A memo v NURSES," dated 12 directed staff to add wrap in tissue and f sharps container," v orders. LACK OF REMOVA MEDICATIONS OR WHEN OPENED T WILL BE OUTDATE During an observati p.m. of the north me	pointing to the sharps to the side of the West hen asked about the door to er compartment being ase of removing the sharps erified the door was unlocked se a key to lock it, but was ked. LPN-B stated, "This key n to lock the door." on 6/10/15, at 10:05 a.m., (DON) stated he was aware tainer compartments were ed during observation, and id be locked." DON verified the the compartments holding the allowed access to the sharps sed Fentanyl patches were had the potential for diversion. would be ordering a new door ation cart because the door he doors were to be locked. sted for ensuring safe and Fentanyl patches, and was not written by DON, to "ALL 2/16/13, was provided, and d, "When removing old patch, flush down toilet or put in when receiving Fentanyl patch AL OF OUTDATED TO DATE MEDICATIONS O DETERMINE WHEN IT	F 4	431			

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/ ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENTI	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	novolin regular was ml multidose vile ou stated the policy ind 28 days after being An observation on 0 first floor medication found and verified k R29's coumadin (a pill outdated for 4-1 R4's coumadin 1 m 4-15; R4's coumadin 2.5 for 4/15; R65's jantoven (a b pills outdated for 4- R65's jantoven 1 m 4-15; R42's jantoven 1 m 4-15; R46's jantoven 1 m 4-15; R10's jantoven 2.5 4-15; In the medication re multidose influenza vials which were ou expiration of 5-15. A multidose tubercu but not dated to det outdated. On the west medic p.m. with LPN-B for (ketam 2%) with ma 5-25-15. An interview on 6/1	a outdated for 5-2-15, lantus 10 utdated for 5-1-15. RN-B dicated multidose vials expire opened. 06/10/2015, at 2:56 p.m. of the n room and the following was by RN-G: blood thinner) 1 mg one (1) 5; ng one (1) pill outdated for mg two (2) pills out outdated blood thinner) 2.5 mg six (6)	F 4	31			

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY IPLETED
		245349	B. WING _		06 / [.]	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STEWAR	TVILLE CARE CENTI	ĒR		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	refrigerator tempera monitored.	as not aware that the atures were not being	F 43	31		
	biologicals indicated after opening" and Dispose of 30 days	ntitled labeling/data of drugs & d "Insulin-Dispose of 28 days Tuberculin - Refrigerate - after opening." I CONTROL, PREVENT	F 44	41		7/17/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must	ion Control Program esident needs isolation to of infection, the facility must				

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		AND HUMAN SERVICES			FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245349	B. WING _		06/	17/2015
NAME OF F	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	transport linens so infection. This REQUIREMEN by: Based on observat review the facility fa equipment was disi bactericide sanitize directions for a gluc residents (R29, R1 ⁻¹ observed. In additic containment of use soiled gloves to pre which could affect s Findings include: R29 had blood gluc 9:22 a.m. registered doing glucose test.	Alicated by accepted bicated by accepted bicated by accepted bicated by accepted bicated by accepted as to prevent the spread of NT is not met as evidenced bion, interview and document biled to ensure glucometer infected according to the r wipe manufacturers cometer used for 3 of 4 1 & R24) glucose tests on the facility failed to ensure d incontinent products and event the spread of infection	F 44		l disease ol and ch as n s a and	
	stated, "I guess we the manufacturers of surface to be disinfor 2 minutes." R11 was observed	uper Sani-Cloth wipe. RN-B wipe it a while." However, directions say to allow the ected to remain wet for a" full to have glucose test done on l. licensed practical nurse		The facility has comprehensive in control policies and procedures c with the current state and federal control regulations and recomme The policies address the surveilla investigation of infections and the maintenance of accurate and comprehensive records of	onsistent infection ndations. nce and	
		ucose monitoring for R11. The noved from the medication		resident/employee infections.		

Facility ID: 00429

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DATE	0938-039 SURVEY PLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		245349	B. WING			06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 20 FOURTH STREET NORTHEAST		
STEWAR	RTVILLE CARE CENT	ER			TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 441	stated the facility a maintained the mot to the medication of of the glucose testi Sani-Cloth wipe to remained in contact one minute and the top of the medicated did not know how le contact with the medicated did not know how le contact with the medicated disinfected to remain R24 had just comp at 6:30 p.m. LPN-E glucometer after us Sani Cloth wipe an the monitor for less finished LPN-B plat of the narcotic bool disinfectant wipe ne monitor for 10 to 15 manufacturers dire to be disinfected to minutes." The undated facility Meters Clean and I meter, wipe down t registered and app toweletteFollow f disinfect the meter. The director of nurs 6/10/15 at 9:57 a.m	ctly into R11's room. LPN-A nd not the resident owned and nitors. When LPN-A returned art following the performance ng, She used the PDI Super clean the meter. The wipe et with the meter for less than a damp monitor was placed on on cart. LPN-A stated that she ong to keep the disinfectant in eter. Again the manufacturers low the surface to be in wet for a" full 2 minutes." leted glucose test on 6/10/15 8 was observed to clean the se. LPN-B used the PDI Super d left the wipe in contact with a than one minute. When ced the damp monitor on top k. LPN-B stated the eeded to be in contact with the 5 second. Again the ctions say to allow the surface remain wet for a" full 2 y policy entitled Blood Glucose Disinfect read, "To disinfect the he meter with an EPA roved premoistened the product label instructions to "	F 4	41	During the July 14, 15 and 16, 2015 mandatory meetings, the licensed nu- were re-instructed on the procedures sanitizing glucometer machines; the nursing staff will sign to verify knowled of the glucometer sanitizing procedur nursing staff were re-instructed on t proper handling of soiled incontinent products and gloves. Compliance will be monitored by the Director of Nurses/designee through direct observation of the nurses; glucometer sanitizing techniques. The charge nurses will observe for proper handling of soiled incontinent products/gloves when supervising resident cares and performing other tasks/treatments in the resident care areas. If noncompliance is noted, additional monitoring and staff educa will be done. Compliance will be revi at the September Quality Assessme Assurance Committee quarterly mee	edge ure. All he t n ne er ation iewed nt and	

Facility ID: 00429

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245349	B. WING			06 /-	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENTE	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 465 SS=B	SPREAD OF INFEC During an observati soiled incontinent p the bathroom floor f number 39 and 40. During an interview licensed practical m soiled incontinent p stated should have LPN-B donned glow pad in the garbage An undated facility p Morning Care) read and dispose of disp linen appropriately.' P.M. Care (Bedtime clean and tidy." An undated facility p Guidelines instructe in a plastic trash ba 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility fa comfortable enviror chips of bathroom o (R95, R96, R75, R8	S TO PREVENT THE CTIONS: on on 6/8/15, at 6:18 p.m. a ad and gloves were laying on between resident rooms on 6/8/15, at 6:22 p.m. urse (LPN)-B verified the product on the floor. LPN-B not been left on the floor, es and placed the incontinent bag and removed from room. bolicy AM Cares (Early , "Leave bedside area clean, osable equipment and soiled ' An undated facility policy e Care) read, Leave room bolicy Incontinence Care ed, "Discard disposable items g and secure." AL/SANITARY/COMFORTABL	F 4	41	It is the policy of Stewartville Care of to provide a safe, functional, sanitar comfortable environment for resider staff, and the public.	ry and nts,	7/16/15

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTU)938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPL	
		245349	B. WING			06/17	7/2015
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETIO DATE
F 465	Continued From pa	ige 80	F 46	5			
	the wheelchair use	d by (R1) was soiled.			a pleasant, homelike environment,		
	Findings include:	dings include: ring an environmental facility tour on			Stewartville Care Center has a schedu for routine cleaning, repairs, and maintenance of the facility. All staff	JIE	
					members are expected to report		
	· · · ·	4 a.m. with maintenance ne following was observed.			environmental concerns to the appropriate administrative/supervisory staff.	oriate	
		throom door jam near the			An additional maintenance check list h	nas	
		witch in the bathroom had sing the metal which was rusty			been implemented for inspection of resident rooms at the time of discharge		
		register in her room also had			and at least yearly for all long term		
		-A stated the door jams need			residents. The condition of the walls,		
		round the light switch and the sty and need painting.			ceilings, bathroom fixtures, and resider care equipment will be checked. Reparand repainting will be done as needed.	air	
		hroom door jams and around					
		paint chipped and were rusty. ho said he will paint.			The condition of the bathroom door jambs, light switches and heat register will be observed and any areas with	rs	
	75's bathroom door	r frame the paint was chipped.			rust/chipped paint will be repainted. Th	he	
		e chipped area's and the need			door jambs in the bathrooms used by		
	for painting those a	reas.			residents number 95, 96, 75, 87, and 1 have been repainted. The light switche		
		or frame near the bottom was			the bathrooms used by residents numb	ber	
	chipped. MM-A ver metal door frame.	rified the chipped paint on the			95 and 96 have been repainted. The h register in the room used by resident	neat	
	metal 0001 mame.				number 96 was repainted. The caulk		
		s soiled, the poles under the			around the toilet in the bathroom used		
		yer of dust, MM-A verified the MM-A stated I suppose its			resident number 11 has been replaced The brown discoloration on the bathroo		
	been a long time si	nce the wheelchair was			floor of resident number 11 is the outlin	ne	
		ne process is the staff bring			of the previous toilet. A new toilet will b	ре	
		is office with a note asking shit. MM-A stated they don't			installed which has a larger base that covers the discolorations. Several staff	ff	
	keep track of which	wheelchairs are washed and			members have checked the bathroom	ı	
	there was no scheo	lule for cleaning wheelchairs.			used by resident 11 during varying time of the day and no unpleasant ambient		
	R11's bathroom in i	room had scratched up door			pervasive odors were detected.	0	

Facility ID: 00429

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
NU PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		245349	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST		
STEWAF	TVILLE CARE CENT	ER		STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 465	was a yellowish dis the toilet. The bath	ulking was yellow and there coloration on the floor around proom had a strong, old urine	F 46	The wheelchair of resident numbe cleaned. A schedule will be develo	ped to	
	was yellow and the An interview on 06/ director of nursing were suppose to be he was not aware of cleaning schedule.	ed that the caulk and flooring bathroom smelled like urine. (11/2015 at 10:54 a.m. the (DON) said the wheelchairs on a cleaning schedule and of the lack of wheelchair cy in regards to general		ensure routine cleaning of all whee During the mandatory meetings Ju 15 and 16, 2015, the staff will be reminded to observe for equipment/furnishings/structures t need to be repaired, cleaned, or re The procedures for reporting work to the Maintenance Director were reviewed.	ily 14, hat eplaced.	
F 490 SS=F	cleaning/repairs we 483.75 EFFECTIVE	ere requested but not received.	F 49	Compliance will be monitored by the administrator through direct observant review of the room maintenant wheelchair cleaning checklists mothree months. If noncompliance is additional auditing and staff educated be done. Compliance will be review the September Quality Assessmert Assurance Committee quarterly motion.	vation ce and nthly for noted, tion will wed at nt and	7/16/15
	enables it to use its efficiently to attain of	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial resident.				
	by: Based on interview administrator failed	NT is not met as evidenced v and document review, the to adequately oversee and ervices related to the		Preparation, submission and implementation of this Plan of Cor does not constitute an admission		

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245349	B. WING			06/-	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 490	Continued From pa	ge 82	F 4	190			
	implementation, an prohibition policies This had the potent currently residing in Findings include: Refer to F223, as the to ensure 2 of 2 rest allegations of staff mistreatment were up and resolution to from occurring. The of staff mistreatment of protection for rest mistreatment, and developing interven abuse, resulted in a 68 residents current remained at risk of and/or mistreatment Refer to F225, as the to report immediates state agency, and in staff abuse, neglec 2 residents (R75, F abuse, neglect, and facility's failure to e were implemented mistreatment, immediates of Health Facility Co- mistreatment and of	d evaluation of abuse and procedures in the facility. tial to affect all 68 residents in the facility. The facility administration failed sidents (R75 and R65) with abuse, neglect, and/or protected and provided follow o prevent further staff abuse e facility's lack of identification int to residents, resulting in lack sidents from staff neglect, abuse, as well as the lack of titions to prevent further staff an immediate jeopardy for all tty residing in the facility who potential staff abuse, neglect,			agreement with the facts and cond set forth in the statement of deficient The facility has appealed the defice and licensing violations stated here Plan of Correction is prepared and executed as a means of continuous improve the quality of care, to corn all applicable state and feral regular requirements and constitutes the fallegation of compliance. Stewartville Care Center is admini- in a manner that enables it to use resources effectively and efficiently attain or maintain the highest prace physical, mental, and psychosocian well-being of each resident. The facility is policies and procedur investigating/reporting of incidents reviewed and found appropriate. Stewartville Care Center policy red that each resident be free from ver- sexual, physical, and mental abuse corporal punishment, and involunts seclusion. The resident will not be subjected to abuse by anyone, inc but not limited to, facility staff, other residents, consultants, volunteers, other agencies serving the resider members or legal guardians, or oth individuals. Stewartville Care Center policy red that all alleged violations involving	encies. iencies. iencies ein. This /or usly uply with atory acility;s stered its y to ticable l ures for were quires rbal, e, ary luding, er staff of it, family her	
	immediate jeopardy	y for all 68 residents currently ty who remained at risk of			that all alleged violations involving resident mistreatment, neglect, ab injuries of unknown source and misappropriation of property be 1) reported immediately to the admin		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIP	LE CONSTRUCTION	OMB NO.	0938-035 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245349	B. WING		06/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 490	Continued From pa	ge 83	F 490			
	ensure a system wa allegations of staff a mistreatment were and state agency in thoroughly investiga ensure allegations of immediately to the agency for 4 of 26 a R99, R98, R97). Refer to F226, as th to implement its abo procedure related to investigation of an a maltreatment, and i	reported to the administrator mediately and were ated. The facility failed to of abuse were reported facility administrator and state allegations reviewed (R64, the facility administration failed use prohibition policy and to resident protection,		 and appropriate state agencies a thoroughly investigated in a time with the investigative results report the administrative staff and state as required. If the alleged violation verified, appropriate corrective a taken. The facility intervenes to p further potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals where been found guilty of abusing, new of actions against an employee would indicate unfitness for service resident care position is investigation is investigation is investigated. Any know of actions against an employee would indicate unfitness for service resident care position is investigation is investigation. 	ly manner orted to officials on is ction is orevent of o have glecting, owledge which ice in a ated and	
	R75) residents revieresidents (R64, R95) reports reviewed. all 68 residents current reviewed. The undarent reviewe			Stewartville Care Center staff rea and respects each resident¿s rig free from maltreatment, neglect, misappropriation of property and that is within its control to prever occurrences. The facility staff 1) residents who are at risk for abu neglect, and/or misappropriation property 2) develops interventior strategies to prevent occurrence routinely reassesses the effective the interventions. During the June 16, 2015 manda training, the facility policies relate abuse prevention/reporting were and all Stewartville Care Center including management staff were instructed on the following: 1) the	ht to be and does all t such identifies se, of s and 3) eness of atory staff ed to reviewed staff	

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	T OF DEFICIENCIES		(Y2) MUT			0938-039
	DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	PLETED
		245349	B. WING _		06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
STEWA	RTVILLE CARE CENT	ER		120 FOURTH STREET NORT STEWARTVILLE, MN 559	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED] DEFICIE	ACTION SHOULD BE	(X5) COMPLETIC DATE
F 490	Continued From pa	ae 84	F 49	90		
	The undated policy State Agencies and read, "All alleged/st substantiated incide immediately to the reported to appropriate 6/11/15 at 9:34 a.m responsibility of the director of nursing, to submit initial repo- investigative report agency. The DON st administrator. DON to be made immediate state agency. DON problem." in regard administrator and st On 6/11/15 at 11:45 worker (LSW) was would usually talk to or nursing if someti Together they decid incident and then re- she could call them in the building and LSW stated she co- needed. LSW state administrator had b he would come in to the policy was to re- On 6/15/14 at 2:24 interviewed. The adv	entitled Reporting Abuse to d Other Entities/Individuals uspected violations and all ents of abuse will be reported Administrator and promptly riate state agencies." sing (DON) was interviewed on and stated that it was the director of nursing, assistant administrator, or social worker orts and the internal s to the state designated stated that he would call the N stated he knew reports were iately to administrator and N stated "We have a system s to immediately reporting to tate agency. 5 a.m. the licensed social interviewed. LSW stated she o the administrator or director hing had been reported to her. ded if it was a reportable eport it to OHFC. LSW stated o on the phone if they were not would always reach them. uld report to OHFC herself if ed she knew that the been notified by phone and that o file the report. LSW stated	Γ 45	 mandated reporter of resident abuse/negled of property 3) the type incidents/accidents the to the common entry p Minnesota Departmer requirement to immed alleged abuse/negled misappropriation of fu supervisory/administra appropriate governme forms and procedures timely reporting and 6 documentation related incidents/accidents. T on vulnerable adult iss twelve months; vulner investigation and repord during new employee facility is Vulnerable A were distributed to all June 17, 2015. The st sign to verify that they information. During the meetings July 14, 15 a staff were reminded o adult investigative and requirements and poli The employee (LPN-E April 24, 2015 inciden number 65 and 75 wa for three days pending the alleged abuse. After the June 2015 st issue, the LPN-e was 	et/misappropriation as of at must be reported boint and/or the at of Health 4) the liately reporting and nds to the ative staff and ental agencies 5) for appropriate and necessary to he staff is educated sues at least every able adult orting are addressed orientation. The adult Abuse policies staff on June 16 and aff were required to received the ne mandatory and 16, 2015, all f the vulnerable d reporting cies. E) involved with the ts with residents s initially suspended g an investigation of er returning to work, nother care unit. tate review of the	

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (2		E SURVEY PLETED
		245349	B. WING			06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pa complaint to the sta	•	F 4	90	continued employment. The program evaluator identified no issues which required treatment/counseling. The employee returned to work and has no further practice/performance issu Resident number 65 ¿ The resident continues to wander throughout the f floor of the facility. She has had no re altercations with staff; her usual resistiveness to bathing continues. T resident has severe cognitive impair and believes that she works at the fa and is a care taker for her grandpare She does not recall the incident from 2015. The social worker frequently interacts with the resident as she wa the social service office several time day. The social worker will meet with resident weekly for four weeks and the monthly for six months to assess mo and behavior. The care plan was rev and found appropriate. Resident number 75 ¿ The resident cognitive deficits and self-propels he wheelchair around the facility. She foo cocasional negative interactions with residents which require staff interver She does not recall the incident from 2015. The social worker will meet with resident weekly for four weeks and the monthly for six months to assess mo and behavior. The care plan was reviewed and found appropriate.	had les. first ecent The ments acility ents. n April alks by us a n the hen bod viewed has er nas n other ntion. n April th the hen bod viewed	

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245349	B. WING	i		06/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From pa	ıge 86	F	490	Residents number 64 ¿ The allege abuse by the resident¿s spouse wa observed 4/15/15 at 4:40 p.m. and not reported to the State agency ur next day. The related facility policy the regulatory requirements for imr reporting were reviewed by the administrative and social service st continued quality improvement pur Resident number 99 ¿ The residen at the facility September 15, 2014. circumstances of the Alleged Resid Abuse Investigation Report Form for incident during the morning of Augu 2014 not being submitted until the afternoon was reviewed by the management staff for continuing qu improvement purposes. Resident number 98 ¿ The residen at the facility December 29, 2014. circumstances regarding a bruise observed 8/10/14 and the 48-hour reporting the bruise to the administ and State agency were reviewed by management staff for continuing qu improvement purposes. The Social Worker will monitor compliance by auditing incident rep timely and appropriate notification of administrator and government offic the next three months. If noncompliance will be done. Compliance will be re during the September Quality Asse and Assurance Committee quarter meeting and ongoing.	as was htil the and mediate aff for poses. It died The dent or an ust 20, uality t died The delay in rrator y the uality borts for of the ses for liance tining viewed assment	

Event ID:LEHX11

Facility ID: 00429

If continuation sheet Page 87 of 97

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/-	17/2015
NAME OF PROVIDER OF	R SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STEWARTVILLE C	ARE CENT	FR			0 FOURTH STREET NORTHEAST		
				SI	TEWARTVILLE, MN 55976		
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	d)(1)-(2) g(Es/appoin	OVERNING BODY-FACILITY IT ADMN	F 4	193			7/16/15
designation body, that and imp manage governir licensed and resp facility This RE by: Based of governir manage implement prohibition This had currently Findings Refer to to ensur allegation mistreat up and r from occo of staff r of proteon mistreat developi abuse, r 68 resid remaine	ed persons at is legally ementing p ment and c ig body app by the Sta ponsible for QUIREMEI on interview g body fail cares and intation, an on policies I the potent residing ir include: F223, as the e 2 of 2 resises ns of staff ment were esolution to curring. The nistreatment ction for resise ment, and a ng interver esulted in a ents current	Ave a governing body, or a functioning as a governing responsible for establishing policies regarding the operation of the facility; and the potential the administrator who is the where licensing is required; the management of the NT is not met as evidenced and document review, the ed to adequately oversee and services related to the d evaluation of abuse and procedures in the facility. ial to affect all 68 residents the facility administration failed sidents (R75 and R65) with abuse, neglect, and/or protected and provided follow o prevent further staff abuse e facility's lack of identification nt to residents, resulting in lack sidents from staff neglect, abuse, as well as the lack of tions to prevent further staff an immediate jeopardy for all thy residing in the facility who potential staff abuse, neglect, at.			Preparation, submission and implementation of this Plan of Correct does not constitute an admission of agreement with the facts and conclu- set forth in the statement of deficien The facility has appealed the deficien and licensing violations stated here Plan of Correction is prepared and/ executed as a means of continuous improve the quality of care, to comp all applicable state and feral regulat requirements and constitutes the fa- allegation of compliance. Stewartville Care Center has a gove body that is legally responsible for establishing and implementing polic regarding the management and ope of the facility. The governing body appoints an administrator who is 1) licensed by the State and 2) respon- for the management of the facility. The facility¿s policies and procedur	f or usions ncies. encies in. This or sly bly with tory ucility¿s erning cies eration	

Facility ID: 00429

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		245349	B. WING _			06 /1	7/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 493	Continued From pa	ige 88	F 49	93			
	Refer to F225, as the to report immediate state agency, and i staff abuse, neglec 2 residents (R75, F abuse, neglect, and facility's failure to e were implemented mistreatment, immediate administrator and s of Health Facility C mistreatment and c investigation of the immediate jeopardy residing in the facilit potential staff abus mistreatment. In addition of the fa ensure a system we allegations of staff mistreatment were and state agency in thoroughly investigations immediately to the agency for 4 of 26 a R99, R98, R97). Refer to F226, as the to implement its abustical	he facility administration failed ely to the administrator and nvestigate all allegations of t, and/or mistreatment for 2 of 865) with allegations of staff d/or mistreatment. The nsure policies and procedures to protect residents from ediate notification of state designated agency (Office omplaints-OHFC) of the completion of a thorough mistreatment resulted in an y for all 68 residents currently ity who remained at risk of e, neglect, and/or acility administration failed to as in place regarding all abuse, neglect, and reported to the administrator nmediately and were ated. The facility failed to of abuse were reported facility administrator and state allegations reviewed (R64, he facility administration failed use prohibition policy and			 investigating/reporting of incidents of reviewed and found appropriate. Stewartville Care Center policy requires that each resident be free from verifies exual, physical, and mental abuse corporal punishment, and involunta seclusion. The resident will not be subjected to abuse by anyone, inclubut not limited to, facility staff, other residents, consultants, volunteers, so ther agencies serving the resident members or legal guardians, or oth individuals. Stewartville Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuinjuries of unknown source and misappropriation of property be 1) reported immediately to the administicative staff and state of as required. If the alleged violation verified, appropriate corrective action taken. The facility intervenes to prefurther potential abuse while the investigation is in process. Stewartville Care Center does not knowingly employ individuals who heen found guilty of abusing, negle 	uires bal, e, ury uding, r staff of t, family er uires use, uires use, strator 1 2) manner ed to fficials is on is vent	
	investigation of an a maltreatment, and administrator and s of Health Facility co	o resident protection, alleged incident of immediately reporting to the state designated agency (Office omplaints-OHFC) for (R65, ewed for abuse and for 4 of 26			or mistreating residents. Any knowl of actions against an employee whi would indicate unfitness for service resident care position is investigate reported to the State nurse aid regi- licensing authorities.	ich in a in and	

Facility ID: 00429

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			PRINTED: 07/17/20 FORM APPROV OMB NO. 0938-03
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
245349	B. WING		06/17/2015
ler		STREET ADDRESS, CITY, STATE, ZIP CO	
ENTER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976	
ENCY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
R99, R98, R97) abuse allegation d. This had the potential to affect currently residing in the facility. related to Abuse Prohibition were undated policy entitled stigating Resident ents stated,"All accidents/incidents ints must be report to the director ces and immediately to the The related procedure directed ents/incidents involving residents hy investigated by management s of such investigation will be kept irector of Nursing." The undated abuse and/or Neglect Investigation ts of resident abuse or neglect thy and thoroughly investigated." olicy entitled Reporting Abuse to and Other Entities/Individuals ed/suspected violations and all neidents of abuse will be reported the Administrator and promptly ropriate state agencies." nursing (DON) was interviewed on a.m. and stated that it was the f the director of nursing, assistant ing, administrator, or social worker reports and the internal ports to the state designated DN stated that he would call the DON stated that he would call the DON stated we have a system gards to immediately reporting to		Stewartville Care Center stat and respects each resident? free from maltreatment, neg misappropriation of property that is within its control to pre occurrences. The facility stat residents who are at risk for neglect, and/or misappropria property 2) develops interver strategies to prevent occurre routinely reassesses the effect the interventions. During the June 16, 2015 mat training, the facility policies re abuse prevention/reporting v and all Stewartville Care Cer including management staff instructed on the following: 1 definition of a vulnerable adu mandated reporter of actual resident abuse/neglect/misa of property 3) the types of incidents/accidents that must to the common entry point at Minnesota Department of He requirement to immediately of abuse/neglect and misappro funds to the supervisory/adm staff and appropriate govern agencies 5) forms and proce appropriate and timely repor necessary documentation re incidents/accidents. The stat on vulnerable adult issues at	s right to be lect, and and does all event such ff 1) identifies abuse, tion of ntion ences and 3) ectiveness of andatory staff elated to vere reviewed ner staff were) the ult 2) who is a or suspected ppropriation t be reported nd/or the ealth 4) the report alleged priation of ninistrative mental edures for ting and 6) lated to if is educated t least every
in the subject of the second s	IDENTIFICATION NUMBER: 245349 PLIER 2ENTER AT STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION) m page 89 4, R99, R98, R97) abuse allegation ed. This had the potential to affect s currently residing in the facility. s related to Abuse Prohibition were undated policy entitled estigating Resident dents stated,"All accidents/incidents ents must be report to the director vices and immediately to the ' The related procedure directed ents/incidents involving residents hly investigated by management gs of such investigation will be kept Director of Nursing." The undated Abuse and/or Neglect Investigation rts of resident abuse or neglect obly and thoroughly investigated." bolicy entitled Reporting Abuse to s and Other Entities/Individuals ed/suspected violations and all incidents of abuse will be reported the Administrator and promptly propriate state agencies." f nursing (DON) was interviewed on 4 a.m. and stated that it was the of the director of nursing, assistant	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245349 B. WING PLIER 245349 SENTER ID PREFID (OR LSC IDENTIFYING INFORMATION) PREFID PREFID TAG m page 89 F 4 R, R99, R98, R97) abuse allegation ed. This had the potential to affect s currently residing in the facility. F 4 s related to Abuse Prohibition were undated policy entitled setigating Resident dents stated,"All accidents/incidents ents must be report to the director <i>vices</i> and immediately to the "The related procedure directed ents/incidents involving residents hly investigated by management js of such investigation will be kept Director of Nursing." The undated Abuse and/or Neglect Investigation rts of resident abuse or neglect othy and thoroughly investigated." ioolicy entitled Reporting Abuse to a and Other Entities/Individuals ed/suspected violations and all incidents of abuse will be reported of the Administrator and promptly propriate state agencies." f nursing (DON) was interviewed on 4 a.m. and stated that it was the of the director of nursing, assistant sing, administrator, or social worker I reports and the internal eports to the state designated DON stated that he would call the DON stated agency.	CARE & MEDICAID SERVICES (X1) PROVIDERSUPPLER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION 245349 B. WING 2LER STREET ADDRESS, CITY, STATE, ZIP OC 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER STREET ADDRESS, CITY, STATE, ZIP OC 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PROVIDER'S PLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PREVIDENT SPLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PREVIDENT SPLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PREVIDENT SPLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PREVIDENT SPLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D PREVIDENT SPLAN OF COR 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER D FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 2HER Stewartville Care Center state and respects each resident/ free from maltreatment, neg misappropriation of property that is within its control to pri- cocurrences. The facility to the stort entis/incidents involving residents the Administrator or social worker I reports and the internal porb to the state agencies." During the June 16, 2015 m: training, the facility policies r instructed on the following: 1 definition of a vulnerable ad, mandated reporter of actual resident abuse/neglect/misa of property 3) the types of incidents/accidents that mus to the common

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		AND HUMAN SERVICES				FORM	07/17/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245349	B. WING _			06/1	17/2015
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER			FOURTH STREET NORTHEAST EWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 493	worker (LSW) was would usually talk to or nursing if someth Together they decid incident and then re- she could call them in the building and LSW stated she co needed. LSW state administrator had b he would come in to the policy was to re- On 6/15/14 at 2:24 interviewed. The ac- not always docume conversations with	interviewed. LSW stated she of the administrator or director hing had been reported to her. ded if it was a reportable eport it to OHFC. LSW stated on the phone if they were not would always reach them. uld report to OHFC herself if ed she knew that the een notified by phone and that of file the report. LSW stated port immediately. p.m. the administrator was dministrator stated he would nt his investigations or residents and staff related to not report every single	F 4		facility¿s Vulnerable Adult Abuse pr were distributed to all staff on June June 17, 2015. The staff were requ sign to verify that they received the information. During the mandatory meetings July 14, 15 and 16, 2015 staff were reminded of the vulneral adult investigative and reporting requirements and policies. The employee (LPN-E) involved wi April 24, 2015 incidents with reside number 65 and 75 was initially sus for three days pending an investiga the alleged abuse. After returning the was assigned to another care u After the June 2015 state review of issue, the LPN-e was requested to complete a Health Professional Se Program evaluation as a condition continued employment. The progra evaluator identified no issues which required treatment/counseling. The employee returned to work and has no further practice/performance iss Resident number 65 ¿ The resider continues to wander throughout the floor of the facility. She has had no altercations with staff; her usual resistiveness to bathing continues. resident has severe cognitive impa and believes that she works at the and is a care taker for her grandpa She does not recall the incident fro 2015. The social worker frequently interacts with the resident as she w the social service office several tim day. The social worker will meet wi	a 16 and irred to , all ole th the nts pended tion of o work, nit. the rvices of um n s had sues. nt e first recent The irments facility rents. m April valks by ues a	

Facility ID: 00429

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			O	FORM MB NO.	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245349	B. WING	à		06/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 493	Continued From pa	age 91	F	493	resident weekly for four weeks and monthly for six months to assess r and behavior. The care plan was r and found appropriate. Resident number 75 ¿ The resider cognitive deficits and self-propels if wheelchair around the facility. She occasional negative interactions w residents which require staff interv She does not recall the incident fro 2015. The social worker will meet resident weekly for four weeks and monthly for six months to assess r and behavior. The resident frequen visits the Social Worker¿s office w obtain a piece of candy from the ca bowl. The care plan was reviewed found appropriate. Resident number 64 ¿ The alleged by the resident¿s spouse was obs 4/15/15 at 4:40 p.m. and was not r to the State agency until the next or related facility policy and the regular requirements for immediate report were reviewed by the administrativ social service staff for continued q improvement purposes. Resident number 99 ¿ The resider at the facility September 15, 2014. circumstances of the Alleged Resid Abuse Investigation Report Form f incident during the morning of Aug 2014 not being submitted until the afternoon was reviewed by the management staff for continuing q improvement purposes.	nood eviewed ht has her e has ith other ention. om April with the d then nood htly ork to andy and d abuse erved eported lay. The atory ing re and uality ht died The dent or an ust 20,	

Facility ID: 00429

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		AND HUMAN SERVICES			FO	RM /	07/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE	SURVEY
		245349	B. WING			06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 493	Continued From pa	ige 92	F 4	.93			
F 497 SS=F	REVIEW-12 HR/YF The facility must co of every nurse aide months, and must p education based or reviews. The in-se sufficient to ensure nurse aides, but mu per year; address a determined in nurse and may address th as determined by th aides providing ser	R INSERVICE mplete a performance review at least once every 12 provide regular in-service in the outcome of these rvice training must be the continuing competence of ust be no less than 12 hours treas of weakness as e aides' performance reviews he special needs of residents he facility staff; and for nurse vices to individuals with ints, also address the care of	F 4	97	Resident number 98 ¿ The resident die at the facility December 29, 2014. The circumstances regarding a bruise observed 8/10/14 and the 48-hour dela reporting the bruise to the administrator and State agency were reviewed by the management staff for continuing quality improvement purposes. The Social Worker will monitor compliance by auditing incident reports timely and appropriate notification of the administrator and government offices for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be review during the September Quality Assessm and Assurance Committee quarterly meeting and ongoing.	y in for e or e g ed ent	7/27/15

Facility ID: 00429

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		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245349	B. WING	à		06/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	ER			I20 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497	Continued From pa	ige 93	F،	497			
	by: Based on interview facility failed to ens received 12 hours of employees (EE-A, I EE-G, EE-H, EE-I, EE-N) who worked assistants and were employed greater th Findings include: Records provided in annual training in th included Tuberculous safety, Client Behav Alzheimer's Client. EE-A, EE-B, EE-C, EE-I, EE-J. EE-K, E were reviewed. EE EE-G, EE-H, EE-I, received a performa months, but the per identify areas for im training. EE-M, EE performance review leave during the tim according to the dir Medical Records (M provided total hours and 2014 for the 13 follows: EE-A was hired in 2	NT is not met as evidenced y and document review, the ure nursing assistants of training annually for 13 of 13 EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L, EE-M, in the capacity of nursing e reviewed who had been han 12 months by the facility. Indicated the facility provided he Healthcare Academy that sis, Fire Safety, Environmental viors, and Caring for the EE-D, EE-F, EE-G, EE-H, EE-L, EE-M, EE-N records -A, EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L had ance review during the past 2 formance review did not hprovement or lack of 12-hour -N had not received a v, but had been on medical he the reviews were completed ector of nursing. MR)-A on 6/16/15 at 12:45 p.m. s of in-service training for 2013 B employees reviewed as 2009 and had received 4.8 2014 and 8.12 hours of			Stewartville Care Center complete performance review of every nurse least once every 12 months, and p regular in-service education based outcome of these reviews. The in-st training ¿ (I) Is sufficient to ensure the contin competence of nurse aides; (ii) Addresses areas of weakness a determined in nurse aides ¿ perforr reviews as well as any special need residents; and (iii) Addresses the care of the cogn impaired. The staff training related policies at procedures were reviewed and rev ensure 12 hours of nursing assista training per year including the train topics of abuse/neglect, fire safety, emergency procedures, tuberculos caring for residents with dementian behaviors. The Health Care Academy online p allows for tracking of training hours certified nursing assistants were re to complete 12 hours of training be July 27, 2015. The required training addressed caring for residents with cognitive impairments and dement related behaviors.	aide at rovides on the service uing as mance ds of hitively nd ised to nt ing his, and related program s. All equired fore	

Facility ID: 00429

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	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATI	0936-039 E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		NG	COM	PLETED
		245349	B. WING _		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWA	RTVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 497	training in 2013. EE-B was hired in 2 hours of training in in 2013. EE-C was hired in 2 of training in 2014 a 2013. In addition E dementia training . safety or emergence EE-D was hired in 2 hours of training in in 2013. EE-F was hired in 2 hours of training in in 2013. In addition dementia training . emergency procede EE-H was hired in 2 hours of training in 2013. In addition dementia training in 2013. EE-I was hired in 2 hours of training in 2013. EE-I was hired in 2 hours of training in 2013. EE-J was hired in 2 hours of training in 2013. In addition EI dementia training. T emergency procedu EE-L was hired in 2 hours of training in 2013. EE-M was hired in 2 hours of training in 2013. EE-M was hired in 2	2010 and had received 2.2 2014 and 2.7 hours of training 2002 and had received 0 hours and 2.7 hours of training in E-C did not receive annual Tuberculosis (TB) training, fire cy procedures training in 2014. 2011 and had received 01.5 2014 and 2.2 hours of training 2007 and had received 3.1 2014 and 3.2 hours of training 2002 and had received 0 2014 and 2.9 hours of training EE-G did not receive annual TB training, fire safety or ures training in 2014. 2002 and had received 9.1 2014 and 0 hours of training in 012 and had received 2.3 2014 and 0 hours of training in 2013 and had received 6.3	F 49	 During the mandatory meetings 14, 15 and 16, 2015, the nursing assistants were instructed on the regulatory requirements and fac policies regarding continuing edu. They were informed that particip the required training is a condition employment. The Business Office Assistant were source responsibilities will mo compliance by auditing the dates nursing assistants; required and performance reviews and the rehours of continuing education hor to their employment anniversary necessary, a specific time will be scheduled for the nursing assist complete the required training. Compliance will be reviewed at the September Quality Assessment Assurance Committee quarterly 	e lity ucation. ating in on of ith human hitor s of the hual quired 12 purs prior date. If e ant to he and	

If continuation sheet Page 95 of 97

		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/	17/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTVILLE CARE CENTI	ER			120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497	EE-N was hired in 2 of training in 2014 a In addition EE-N did training . TB training procedures training Training records pro- since February 201 EE-X had not comp programs entitled C for Alzheimer's Clie EE-R was hired as 3/25/15. EE-R's tra- completion of deme EE-U was hired as 4/28/15. EE-U's tra- completion of deme EE-X was hired as 5/12/15. EE-X'w tra- completion of deme During an interview p.m. the director of responsible for staf stated records were During an interview ADON stated the ad- training programs to the Healthcare Aca stated the Tubercul dementia/behavior as part of orientatio program. The ADO 6/10/15 at 2:10 p.m	2010 and had received 0 hours and 0 hours of training in 2013. d not receive annual dementia g, fire safety or emergency in 2014. ovided for employees hired 5 showed that EE-R, EE-U, oleted the two Health Academy Client Behaviors and Caring int as follows: a nursing assistant on aining record did not document entia training. a nursing assistant on aining record did not document entia training. a nursing assistant on aining record did not document entia training. a nursing assistant on aining record did not document entia training.	F 4	197			

If continuation sheet Page 96 of 97

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245349 B. WING 06/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 (X3) DATE SURVEY COMPLETED			AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STEWARTVILLE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID F 497 Continued From page 96 F 497 During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. F 497 Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
STEWARTVILLE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 497 Continued From page 96 F 497 During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. F 497 Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports			245349	B. WING			06 / [.]	17/2015
STEWARTVILLE CARE CENTER STEWARTVILLE, MN 55976 Image: Care of the process o	NAME OF F	PROVIDER OR SUPPLIER	•					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 497 Continued From page 96 F 497 During an interview on 6/15/15 at 1:30 p.m. the administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. F 497 Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports	STEWAR	TVILLE CARE CENT	ER					
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administrator stated he felt staff was completing the training programs since he offered and paid a financial incentive to employees to do so. Undated policy entitled Employee In-Service Program was provided. The procedure indicated Healthcare Academy eLearning services was used and offered to be completed at home or at work by the employee. A designated dead line for completion would be determined by administration and department heads. In addition to the assigned courses, additional courses could be added on an as needed basis. The procedure also noted the employee and administration could track the training progress and generate reports	F 497	Continued From pa	lge 96	F4	197			
		During an interview administrator stated the training program financial incentive t Undated policy enti Program was provid Healthcare Academ used and offered to work by the employ completion would b administration and to the assigned cou- be added on an as also noted the emp track the training pr	on 6/15/15 at 1:30 p.m. the d he felt staff was completing ns since he offered and paid a o employees to do so. tled Employee In-Service ded. The procedure indicated ny eLearning services was o be completed at home or at vee. A designated dead line for be determined by department heads. In addition urses, additional courses could needed basis. The procedure loyee and administration could rogress and generate reports					

Facility ID: 00429

If continuation sheet Page 97 of 97

D PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	IPLE CONSTRUC			TE SURVEY MPLETED
	l.	245349	B. WING			06	/09/2015
AME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CO	ODE	
TEWAR	TVILLE CARE CENT	ER			STREET NORTHEAST LLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF COR H CORRECTIVE ACTION -REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMENT	ſS	K 0	00			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Stewartville Care C substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, enter was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety er 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal	R THE FIRE SAFETY			EPO	C	

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			O		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · ·		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245349	B. WING			06/0	9/2015
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR			20 FOURTH STREET NORTHEAST		
STEWAN				S	TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	К 0	000			
	By email to: Marian.Whitney@s Angela.Kappenmar						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the deficient	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	building was constr original building was determined to be of 1976, addition was	enter is a 2-story building. The ucted at 2 different times. The s constructed in 1970 and was f Type II(111) construction. In constructed and was f Type II(111) construction.					
	are of the same typ construction type al	al building and the 1 addition the of construction and meet the llowed for existing buildings, reyed as one building.					
	fire alarm system w detection and space	sprinkled. The facility has a vith full corridor smoke es open to the corridors that is natic fire department					
	The facility has a ca census of 68 at the	apacity of 85 beds and had a time of the survey.					at Dago 2 of 5

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Facility ID: 00429

If continuation sheet Page 2 of 5

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. ((X3) DATE	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		LETED
		245349	B. WING		06/0	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	ge 2	K 00	0		
K 018	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 01	8		7/15/15
SS=D	required enclosures hazardous areas ar those constructed of wood, or capable of minutes. Doors in required to resist th no impediment to th are provided with a	prridor openings in other than s of vertical openings, exits, or re substantial doors, such as of 1 ³ / ₄ inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is ne closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 0.3.6.3				
	Roller latches are p in all health care fa	rohibited by CMS regulations cilities.				
	Based on observat facility did not have requirements of NF	s not met as evidenced by: ion and staff interview, the a corridor door that meets the PA 101 LSC (00) Section icient practice could affect 2		Doors stops have been installed doors to resident rooms number 38. The stops will serve to preve doors from slamming shut due to currents when the residents ope windows. The plan is to install do on all doors of resident rooms.	36 and nt the o air n their	

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Hand Street Street

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Event ID: LEHX21

Facility ID: 00429

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245349	B. WING		06/	09/2015
		1 10010		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2013
		ER		120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 018	Continued From pa Findings include:	ige 3	K 018	The staff will be alert to residents		
	on 06/09/2015, it w Level - resident roc	veen 10:00 AM and 12:30 PM as observed that the Lower oms # 36 and 38, have trash door open due to the doors		physically propping their doors op will counsel with residents as nec regarding the fire hazard related t practice. The Maintenance Direct monitor completion of the door sta installation.	essary o this or will	
	NOTE: Check the v	whole facility for this deficiency	13	instantion.		
	Facility Maintenance discovery.	ice was confirmed by the e Director (DH) at the time of				0.4545
K 025 SS=D	Smoke barriers are least a one half hou accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate compartm floor. Dampers are penetrations of smo	FETY CODE STANDARD constructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems. 19.1.6.3, 19.1.6.4	K 025			6/15/15
	Based on observation facility failed to main accordance with the 2000 NFPA 101, Second	s not met as evidenced by: tion and staff interview, the ntain corridor wall in e following requirements of ection 19.3.7.3, 8.3.2 and practice could affect 10 out of		The open penetration in the fire v above the lay ceiling by resident r number 39 has been sealed with intumescent fire stop caulk. All ot smoke barrier walls will be inspect open penetrations and caulked as	oom ner ted for	

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Facility ID: 00429

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM /	07/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY
		245349	B. WING			06/0	9/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STEWARTVILLE CARE CENTER					20 FOURTH STREET NORTHEAST TEWARTVILLE, MN 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 025	Continued From pa	ge 4	K)25	necessary. The integrity of the fire w be checked after subcontractor wor	vall will k near	
	On facility tour betw on 06/09/2015, obs Lower Level - smok	veen 10:00 AM and 12:30 PM ervation revealed that the the barrier wall by resident enetration above lay in ceiling.			fire wall barriers.		
	NOTE: All smoke b from exterior wall to	arriers need to be checked exterior wall.					
	This deficient practi Facility Maintenanc discovery.	ice was confirmed by the e Director (DH) at the time of					
	TEAM COMPOSIT Gary Schroeder, Lit	⊓ON fe Safety Code Spc.			*		
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Facility ID: 00429

If continuation sheet Page 5 of 5



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 7, 2015

Mr. Eugene Gustason, Administrator Stewartville Care Center 120 Fourth Street Northeast Stewartville, Minnesota 55976

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5349025

Dear Mr. Gustason:

The above facility was surveyed on June 8, 2015 through June 17, 2015 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

Stewartville Care Center July 7, 2015 Page 2

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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: Fax:

Enclosure(s)

cc: Original - Facility Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/17/15

Electronically Signed

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If continuation sheet 1 of 75

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00429		00429	B. WING		06/17/20 ⁻	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the ment of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of c	rough June 17, 2015 epartment's staff, visited the I the following correction Please indicate in your orrection that you have lers, and identify the date when ted.	n			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column Fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
	00429		B. WING		06/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEWAR	TVILLE CARE CENTI	-8	RTH STREET IVILLE, MN	NORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	THIS WILL APPEA	R ON EACH PAGE.			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 130	MN Rule 4658.0050 duties) Subp. 1 Licensee;General	2 130		6/17/15
	nursing home is res control, and operati managed, controlle that enables it to us efficiently to attain o	I duties. The licensee of a sponsible for its management, on. A nursing home must be d, and operated in a manner se its resources effectively and or maintain the highest I, mental, and psychosocial resident.			
	by: Based on interview administrator failed monitor care and se implementation, an prohibition policies	ent is not met as evidenced and document review, the to adequately oversee and ervices related to the d evaluation of abuse and procedures in the facility. ial to affect all 68 residents the facility.		See POC for F223, F225 and F226	
	Findings include:				
	to ensure 2 of 2 res allegations of staff a mistreatment were up and resolution to from occurring. The	ne facility administration failed idents (R75 and R65) with abuse, neglect, and/or protected and provided follow o prevent further staff abuse e facility's lack of identification nt to residents, resulting in lack			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00429		B. WING		06/17/2015	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FB	RTH STREET I TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 130	Continued From pa	age 3	2 130			
	of protection for residents from staff neglect, mistreatment, and abuse, as well as the lack of developing interventions to prevent further staff abuse, resulted in an immediate jeopardy for all 68 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment.					
	to report immediate state agency, and i staff abuse, neglec 2 residents (R75, F abuse, neglect, and facility's failure to e were implemented mistreatment, imm administrator and s of Health Facility C mistreatment and c investigation of the immediate jeopard	the facility administration failed ely to the administrator and investigate all allegations of et, and/or mistreatment for 2 of R65) with allegations of staff d/or mistreatment. The ensure policies and procedures to protect residents from ediate notification of state designated agency (Office complaints-OHFC) of the completion of a thorough mistreatment resulted in an y for all 68 residents currently ity who remained at risk of se, neglect, and/or				
	ensure a system w allegations of staff mistreatment were and state agency in thoroughly investig ensure allegations immediately to the	acility administration failed to vas in place regarding all abuse, neglect, and reported to the administrator mmediately and were ated. The facility failed to of abuse were reported facility administrator and state allegations reviewed (R64,				
		he facility administration failed buse prohibition policy and				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION	(X3) DATE	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
			R WING			17/2015	
		00429	B. WING	B. WING 0			
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN १				
(X4) ID			ID			(X5) COMPLET	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
2 130	Continued From pa	age 4	2 130				
	procedure related t	o resident protection,					
	investigation of an	alleged incident of					
		immediately reporting to the					
		state designated agency (Office	9				
		omplaints-OHFC) for (R65, ewed for abuse and for 4 of 26					
		9, R98, R97) abuse allegation					
		This had the potential to affect					
		rently residing in the facility.					
	Eacility policies rela	Facility policies related to Abuse Prohibition were					
	reviewed. The undated policy entitled						
	Reporting/Investigating Resident						
		s stated,"All accidents/incidents	3				
		must be report to the director					
		and immediately to the					
		related procedure directed incidents involving residents					
		nvestigated by management					
		such investigation will be kept					
		tor of Nursing." The undated					
		e and/or Neglect Investigation					
		f resident abuse or neglect					
		nd thoroughly investigated."					
		entitled Reporting Abuse to doubter to doubter of the doubter of t					
		uspected violations and all					
		ents of abuse will be reported					
		Administrator and promptly					
	reported to appropri	riate state agencies."					
	The director of nurs	sing (DON) was interviewed or	1				
	6/11/15 at 9:34 a.m	and stated that it was the					
		director of nursing, assistant					
		administrator, or social worker					
		orts and the internal					
		s to the state designated					
		stated that he would call the N stated he knew reports were					
		iately to administrator and					
inesota D	epartment of Health		I				

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF		FR	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	Continued From pa	ge 5	2 130			
		I stated "We have a system s to immediately reporting to tate agency.				
	worker (LSW) was would usually talk to or nursing if someth Together they decid incident and then re she could call them in the building and LSW stated she co needed. LSW state administrator had b	a.m. the licensed social interviewed. LSW stated she of the administrator or director hing had been reported to her. led if it was a reportable eport it to OHFC. LSW stated on the phone if they were not would always reach them. uld report to OHFC herself if ed she knew that the een notified by phone and that of file the report. LSW stated port immediately.				
	interviewed. The ac not always docume conversations with	p.m. the administrator was Iministrator stated he would nt his investigations or residents and staff related to not report every single tte agency.				
	The Governing Boa and implement poli- the administrator ro develop monitoring compliance and rep Assurance Commit oversight of the fun	THOD OF CORRECTION: and or designee could develop cies and procedures related to ble and educate all staff. Then systems to ensure ongoing port the findings to the Quality tee and have effective ctions of the home related to t/cares/services for residents.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
Minnesota D	epartment of Health					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SUF COMPLET	
	00429		B. WING		06/17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
TEWAR	TVILLE CARE CENT	FR	RTH STREE ⁻ RTVILLE, MN	F NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 285	Continued From pa	age 6	2 285			
2 285	MN Rule 4658.010 Orientation and In-	0 Subp. 2 Employee Service Education	2 285			7/27/15
	continuing compete address areas iden assessment and a must address the s determined by the home must provide program in rehabilit to promote ambula living; assist in activ of range of motion,	sufficient to ensure the ence of employees, must atified by the quality assurance committee, and special needs of residents as nursing home staff. A nursing e an in-service training tation for all nursing personnel tion; aid in activities of daily vities, self-help, maintenance and proper chair and bed the prevention or reduction of				
	by: Based on interview facility failed to ens received 12 hours of employees (EE-A, EE-G, EE-H, EE-I, EE-N) who worked assistants and were	ent is not met as evidenced and document review, the sure nursing assistants of training annually for 13 of 13 EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L, EE-M, in the capacity of nursing e reviewed who had been han 12 months by the facility.	3	See POC for F497		
	Findings include:					
	annual training in th included Tuberculo	ndicated the facility provided he Healthcare Academy that sis, Fire Safety, Environmenta viors, and Caring for the				
		, EE-D, EE-F, EE-G, EE-H, EE-L, EE-M, EE-N records				

	ota Department of He		1			
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00429		B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 285	Continued From pa	ige 7	2 285			
	EE-G, EE-H, EE-I, received a perform months, but the per identify areas for im training. EE-M, EE performance review leave during the tim according to the dir Medical Records (M provided total hours	E-A, EE-B, EE-C, EE-D, EE-F, EE-J. EE-K, EE-L had ance review during the past 2 rformance review did not provement or lack of 12-hour -N had not received a v, but had been on medical he the reviews were completed rector of nursing. MR)-A on 6/16/15 at 12:45 p.m. s of in-service training for 2013 8 employees reviewed as				
	hours of training in training in 2013. EE-B was hired in 2 hours of training in in 2013. EE-C was hired in 2 of training in 2014 a 2013. In addition E dementia training . safety or emergence EE-D was hired in 2 hours of training in in 2013. EE-F was hired in 2 hours of training in in 2013. EE-G was hired in 2 hours of training in in 2013. In addition dementia training . emergency procede EE-H was hired in 2	2009 and had received 4.8 2014 and 8.12 hours of 2010 and had received 2.2 2014 and 2.7 hours of training 2002 and had received 0 hours and 2.7 hours of training in E-C did not receive annual Tuberculosis (TB) training, fire cy procedures training in 2014. 2011 and had received 01.5 2014 and 2.2 hours of training 2007 and had received 3.1 2014 and 3.2 hours of training 2002 and had received 0 2014 and 2.9 hours of training EE-G did not receive annual TB training, fire safety or ures training in 2014. 2002 and had received 9.1 2014 and 0 hours of training in				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00429		B. WING		- 06/17/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	-	
TEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 285	Continued From pa	age 8	2 285			
	hours of training in 2013. EE-J was hired in 2 hours of training in EE-K was hired in of training in 2014 2013. In addition E dementia training. emergency proced EE-L was hired in 2 hours of training in 2013. EE-M was hired in hours of training in training in 2013. EE-N was hired in of training in 2014 In addition EE-N di	1996 and had received 0 hours and 4.8 hours of training in E-K did not receive annual TB training, fire safety or ures training in 2014. 2022 and had received 2.3 2014 and 0 hours of training in 1980 and had received 2.6 2014 and 4.32 hours of 2010 and had received 0 hours and 0 hours of training in 2013. Id not receive annual dementia 19, fire safety or emergency				
	since February 201 EE-X had not com	rovided for employees hired 15 showed that EE-R, EE-U, pleted the two Health Academy Client Behaviors and Caring ent as follows:				
	3/25/15. EE-R's tra completion of demo EE-U was hired as 4/28/15. EE-U's tra completion of demo EE-X was hired as	a nursing assistant on aining record did not document entia training. a nursing assistant on aining record did not document				
		v on entrance on 6/8/15 at 3:00 f nursing (DON) stated the				

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 285		-	2 285			
	responsible for stat	f nursing (ADON) was ff development. DON also e kept per calendar year.				
	ADON stated the a training programs t the Healthcare Aca stated the Tubercu dementia/behavior as part of orientatic program. The ADO 6/10/15 at 2:10 p.m	v on 6/10/15 at 2:00 p.m. the dministrator would assign the o be viewed by staff through demy online program. ADON losis training program were offered on and annual training 'N was interviewed again on n. and stated she was hitor staff training, but she did				
	administrator state the training program	v on 6/15/15 at 1:30 p.m. the d he felt staff was completing ms since he offered and paid a to employees to do so.				
	Program was provi Healthcare Acaden used and offered to work by the employ completion would b administration and to the assigned cou be added on an as also noted the emp	department heads. In addition urses, additional courses could needed basis. The procedure ployee and administration could rogress and generate reports				
	administrator could regards to staff hav the needs of all res	THOD OF CORRECTION: The I monitor for compliance in ving ongoing education to meet idents especially in regards to t resident behavior and nent.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00429	B. WING		06/17/2015			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST								
STEWAR	TVILLE CARE CENT	FR	RTH STREET					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE		
2 285	Continued From pa	ge 10	2 285					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one						
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			7/27/15		
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144							
	Alzheimer's disease or related of segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	1					
	 (b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. 	of Alzheimer's disease and activities of daily living; with challenging behaviors;						
	by:	ent is not met as evidenced and document review, the		See POC for F497				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FB	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	age 11	2 302			
	(EE-0, EE-P, EE-R EE-X, EE-Y, EE-Z)	ure that 10 of 10 employees , EE-S, EE-T, EE-U, EE-W, reviewed for having received vere found to have not nentia training.				
	Findings include:					
	Program was provi Healthcare Acaden used and offered to work by the employ In-service TB [tube also "Client Behavi	tled Employee In-Service ded. The procedure indicated by eLearning services was be completed at home or at vee. The procedure read, "J. rculosis] it's a Cough Away" or" and "Caring for Alzheimer's mpleted before starting work."	5			
	(CMS671 and CMS residents currently	mation provided the facility 6672) noted the facility had 68 in the facility and that included ementia and 20 residents that aviors.				
	The training record following new hires	s were reviewed for the :				
	Records provided i courses had been of EE-P hired 3/17/15 Records provided i courses had been of EE-R hired 3/25/15 Records provided i courses had been of	as a dietary staff member. ndicated neither of the two completed. as a nursing assistant. ndicated neither of the two completed.				
	Records provided i courses had been o EE-T hired 4/8/15 a	as a dietary staff member. ndicated neither of the two completed. as a dietary staff member. ndicated neither of the two				

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00429	B. WING		06/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF		ED	RTH STREET FVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 12	2 302			
	courses had been of EE-U hired 4/28/15 Records provided in courses had been of EE-W hired 5/5/15 employee. Records the two courses had EE-X hired 5/12/15 Records provided in courses had been of EE-Y hired 6/3/15 a was observed durin floor as a new emp Records provided in courses had been of EE-Z was hired 1/1 nurse. Records pro- two courses had been EE-Z was hired 1/1 nurse. Records pro- two courses had been the assistant direct interviewed on 6/10 she was responsibl ADON stated she w employees had not cognitively impaired The director of nurs 6/10/15 at 2:20 p.m employees were to added the residents dispersed on all the area. SUGGESTED MET The director of nurs an orientation progra	completed. as a nursing assistant. ndicated neither of the two completed. as a medical record a provided indicated neither of d been completed. as a nursing assistant. ndicated neither of the two completed. as a registered nurse. EE-Y ing the survey working on the loyee with another nurse. ndicated neither of the two completed. 2/15 as a licensed practical vided indicated neither of the een completed. 2/15 at 2:10 p.m. ADON stated e to monitor staff training. vas not aware that the ten new been trained in caring for the d resident. sing was interviewed on and stated that all new be trained on dementia. He is with dementia were e wings and not in just one THOD OF CORRECTION: sing or designee could develop ram and monitoring system new employees receive rvice training related to caring				

Minneso	ta Department of He	alth			FORM APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00429	B. WING		06/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEWAR	TVILLE CARE CENTI	FB	RTH STREET IVILLE, MN	NORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 302	Continued From pa	ge 13	2 302		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		7/17/15
	comprehensive plat objectives and time long- and short-tern and mental and psy identified in the com assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).			
	by: Based on record re failed to develop a of mood, behavior and of 5 residents (R45 medications. Findings include: R45 was admitted to to the facility admiss that included but was disorder. R45's significant ch	ent is not met as evidenced view and interview, the facility comprehensive care plan for d psychotropic drug use for 1) who received psychotropic to the facility 6/12/14 according sion record with diagnoses as not limited to bipolar lange Minimum Data Set 5 indicated moderate		See POC for F280	
	depression with a P interview) score of 9 bipolar disorder, an care rejection, and when compared to addition, the MDS in antipsychotic and a	PHQ-9 (resident moderate 9, identified diagnosis of d indicated behavior status, wondering had worsened previous assessment. In ndicated R45 received ntidepressant medications. nent (CAA's) were triggered			

Minneso	ta Department of He	alth				APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00429	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		120 FOUR		NORTHEAST		
STEWAR	TVILLE CARE CENT	EB	TVILLE, MN			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH		COMPLETE DATE
				DEFICIENCY)	
2 560	Continued From pa	ge 14	2 560			
	•	-				
		OS assessment information of care. The CAA's triggered				
		DS assessment included:				
		oral symptoms, and				
	psychotropic drug u					
		lers provided by the facility on				
		exapro (antidepressant				
	medication) 20 milli	igrams (mg) once per day,				
		depressant medication) 300				
		ene (anti-seizure medication				
		abilizer) 250 mg two times per				
		antipsychotic medication) 5 mg				
	at bedtime.	not include a plan of care that				
		zed goals and interventions for				
		areas for behavioral symptoms				
		rug use. Although depression				
		care plan lacked interventions				
		and services associated with				
		sociated mood state concerns.				
		on 6/10/15 at 1:00 p.m., the				
		censed practical nurse e care plan did not reflect the				
		the MDS. LPN-G stated mood				
		mptoms, and psychotropic				
		ve been included in the care				
	plan.					
	The facility policy N	linimum Data Set/Resident				
		col/Care Planning that was not				
		ect current standards.				
		HOD OF CORRECTION:				
		sing or designee could				
		id/or revise policies and ire care plans are developed to				
		care of residents. The				
		or designee could educate all				
		the policies and procedures,				
		monitoring systems to ensure				
	ongoing compliance					

Minneso	ta Department of He	alth			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (/	(3) DATE SURVEY COMPLETED
		00429	B. WING		06/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEWAR	TVILLE CARE CENTI	FB	RTH STREET IVILLE, MN	NORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 560	Continued From pa	ge 15	2 560		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570		7/17/15
	interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required			
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to revised the plan of dietician's recommendations R65) reviewed.		See POC for F325	
	Findings include:				
	supplement was giv amount consumed amount consumed to determine if there in stabilizing weight (RD)-B's progress r staff to monitor inta	e supplement however, the ven to the resident but the was not documented and the of meals was not documented e was an effective intervention closs. The registered dietician note dated 5/7/15, indicated ke; although, The need for d supplement intake was not re plan.			

TATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
IAME OF PROVID	ER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
STEWARTVILL	E CARE CENT	FR	IRTH STREET RTVILLE, MN	NORTHEAST 55976		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570 Cont	inued From pa	age 16	2 570			
able need provi apply An ir certif wand weig The times she d	to feed self aff s observing if ed." The liste de setup for re condiments, terview on 06/ ied dietary ma ders up and do ht this month, nurses gave h s a day. No or	ted 2/2/15, indicated R65 "Is ter setup is provided and she is eating and assist as d approach is "One staff to each meal-open containers, cut foods and butter breads." /10/2015 at 12:32 a.m. with mager (CDM) who said R65 own the hallway. She lost currently she weighs 114 lbs. er a house supplement three he keeps track of how much but they will start keeping				
regis her r times walk loss her v "She mon looke	tered dietician neals well and a day. R65 e ng so much. of 9.2% for the veight loss is 1 is on the risk hs now." RD-	/11/2015, on 8:48 a.m. (RD)-B said R65 consumes takes a supplement three xpels a lot of energy by In May 2015, she had a weight e past six months. As of today 1.6% for the past six months. list and being monitored for B continued to say I haven't nurses are signing out for her				
regis hous	tered nurse (F e supplement	/11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said no nuch is consumed.				
"Ni and '	ursing service Need for an ir	00, entitled supplements read record intake of supplement" ntake of supplement will be ng personnel."	,			
SUG	GESTED MET	THOD OF CORRECTION:				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/	17/2015
		120 FOU		NORTHEAST		
		SIEWAR	TVILLE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ige 17	2 570			
	develop, review, an procedures to ensu ensure appropriate Director of Nursing appropriate staff on	rsing or designee could ind/or revise policies and irre care plans are developed to care of residents. The or designee could educate all in the policies and procedures, monitoring systems to ensure e.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			7/16/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident h bed.				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and record ailed to reassess pain after a n for 2 of 2 residents (R11 & in.		See POC for F309		
	Findings include:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN १			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	and stated she had shoulders. R11 stat medication for it an pain in the area tha (scale 0 no pain an she used Ultram (p she had "out-grown needed to have bot repaired, but did no 6/11/15 at 6:15 p.m her chair and eating	ed on 06/09/2015 at 10:26 a.m. I lots of pain in her back and ted she took a lot of pain ad stated that she currently had at she would rate almost a 10 ad 10 severe pain). Stated that bain medication), but felt that in it." R11 stated that she th rotator cuffs (shoulders) of want surgery again. On a. R11 was observed sitting in g her meal. R11 stated her at a 10 out of 10 and that done for her.				
	diagnoses listed or included: chronic p Physician orders of Ultram twice a day scheduled Tylenol	to the facility in 2006 and had in the physician orders that ain and osteoarthrosis. f 6/11/15 included: scheduled and as needed (PRN), extra strength twice a day, narcotic medication) three				
	otherwise continue to her arthritis in he failed all conservati	vsician note read, "Patient s to have symptoms in regards er shoulders. Patient also has ive therapies for that." degenerative joint disease - mptomatic."	\$			
	R11 had a BIMS (b of 15 or no cognitiv R11 had rated her	num Data Set (MDS) indicated orief interview of mental status) re impairment and indicated pain at 6 out of 10 but that an in was not necessary.				
	7/9/14 indicated the	essment (CAA) completed e resident would rate her pain ers and arms, that she				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06 /	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 19	2 830			
	medications, had li range of motion. T risk for increased s her quality of life, fo	d and as needed (PRN) pain mited bilateral functional The CAA read, "She may be at [symptoms] of pain limiting or falls and injury."				
	dated 3/23/15 note	d the resident had occasional hard to sleep, and would rate of 10. No further				
	licensed practical r usually had pain ar wanted her to have The facility would a LPN-J stated she t the "gas" (air in box	y on 6/11/15 at 6:24 p.m. hurse (LPN)-J stated R11 hd that the physician only e pain medications for control. Ilso provide warm packs. hought the pain was related to wels) in the abdomen and that he a rectal tube and anti-gas				
	regards to a pain a stated that she was assessments and a	v on 6/11/15 at 11:30 a.m. in ssessment for R11, RN-F s just starting to do pain any pain assessment would be art. However, none was ed when requested.				
	stated that her legs her bottom was so of the Hoyer mecha	d on 6/8/15 at 6:29 p.m. and s ached. R2 also stated that re because of cancer and use anical lift. R2 stated her pain ut of 10 scale, but currently dic	ł			
		ce on 4/7/15 documentation I she was having more pain				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
	PROVIDER OR SUPPLIER	4	DDRESS, CITY, ST		00/	17/2013
	TVILLE CARE CENT	120 FOI	JRTH STREET			
	IT VILLE CARE CENT	STEWAR	RTVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 20	2 830			
	ankle pain and swe	ntation of 4/20/15 noted right elling for R2. The nursing 5/20/15 through 6/11/15 did not dent having pain.	t			
	BIMS of 14 or no c section was left un	lated 12/23/14 indicated a cognitive impairment, the pain done. The quarterly MDS cated a pain intensity of 7 on a				
		ed 4/6/15 indicate the resident ut and generalized pain usually lers.				
	coordinator, stated	11:30 a.m. RN-F, the MDS that she was just starting to de and had not done any for R2	o			(X5) COMPLE
	Pain Evaluation Pr pain was to be rea condition indicates On 06/11/2015 at 1 nursing stated he w assessments be co	12:03 p.m. the director of				
	director of nursing give direct care the ongoing assessme	THOD OF CORRECTION: The could in-service all staff who e need to assess and provide ents and cares related to ds. Also to monitor for staff	9			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00429	B. WING		06/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
STEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	NORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 965	Continued From pa	ige 21	2 965		
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965		7/17/15
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	•		
	This MN Requirement is not r by: Based on observation, intervie review, the facility failed to con reassess nutritional status for (R65) reviewed for nutritional	ion, interview and document ailed to comprehensively al status for 1 of 3 residents		See POC for F325	
	Findings include:				
	180 days however,	nt weight loss over the past interventions put in place l/assessed if appropriate to eight.			
	supplement was giv actual amount cons and the amount con documented to dete	e supplement however, the ven to the resident but the sumed was not documented nsumed of meals was not ermine if there was an on in stabilizing weight loss.			
	progress note date reflected weight los past 30 days, six po and 16 pounds (12	weight from dietary resident d 6/10/2015, was 114 pounds s of four pounds (3.4 percent) ounds (5 percent) past 90 days .3 percent) past 180 days. ificant past 180 days. Dietary			

STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 22	2 965		,	
	resident's current v weight six months weight loss of 9.2 p Recommended hor to four ounces thre further weight loss monitor intake. R65 was admitted dementia and CVA A quarterly Minimur 4/28/15, identified I eating. the MDS a problems with coug complaints of diffic significant change required supervisio or cueing during m 128 pounds at that		•			
	6/9/15, with the onl meals consumed w which indicated an supplement to 4 oz loss." On 5/22/15, around 6 hours wa offered food, fluid No other mention of	totes reviewed from 3/17/15, to y time when the amount of vas mentioned was on 5/12/15 "increase in house with each meal for weight the progress note read, "Up ndering up and down halls. ds and activity as appropriate." of food consumed was any provided when requested.				
	until 6/10/15, indica house supplement consumed. The m until 5/31/15, indica supplement with th	eets reviewed from 3/1/15, ate R65 given four ounces of but no monitoring of amount edication flow sheet for 3/1/15, ate once a day house ree times a day started on eights also listed on medication				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 23	2 965			
	sheet during this pe	eriod.				
	indicated no conce	l assessment dated 1/28/15, erns at that time and no further nents were provided since that				
	received from certi- weight on 1/5/15, 1	ed weight variance report fied dietary manager (CDM), 27.8 pounds (lbs); 2/2/15, 124 lbs; 4/1/15, 120 lbs; 5/1/15, 14 lbs.	ŀ			
		/10/15, at 12:06 p.m. R65 ate On 6/11/15, at 12:03 p.m. R65				
	CDM who said R65 hallway. She lost w weighs 114 lbs. Th supplement three t	/10/2015 at 12:32 a.m. with 5 wanders up and down the weight this month, currently she ne nurses give her a house imes a day. However, no one much she eats at a meal but ing track now.	9			
	said R65 consume supplement three t energy by walking s had a weight loss of As of today her wei six months. "She is monitored for mont	/11/2015, on 8:48 a.m. RD-B is her meals well and takes a imes a day. She expels a lot of so much. In May 2015, she of 9.2% for the past six months ight loss is 11.6% for the past s on the risk list and being ths now" and I haven't looked are signing out for her ient.				
	registered nurse (F house supplement	/11/2015, at 9:09 a.m. with RN)-G who said R65 takes her three times a day but said s how much is given nor does				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 24	2 965			
	anyone record how	much is consumed by R65.				
	9:14 a.m. both said much supplement t	D and CDM on 06/11/2015, at I they have not assessed how the resident consumes. They not assess effectiveness of the s not monitored.				
	director of nurses (expectation is the c of the meal R65 ea monitor how much	(11/2015, at 9:55 a.m. with DON) who stated my dietary staff monitor how much ats and nursing needs to supplement R65 consumes of ien they give it to her.				
	feed self after setu observing if she is The listed approach for reach meal-ope	ted 2/2/15, read, "Is able to p is provided and needs eating and assist as needed." h is "One staff to provide setup on containers, apply ods and butter breads."	,			
	preventing ongoing residents in the fac they exhibit an une	ntitled monitoring and weight loss read, "All ility will be weighed monthly. If xpected continual weight loss will be addressed as a risk ns will begin."	f			
	nutritional risk read following conditions Nutritional risk: Lov	00, entitled residents at l, "Residents with any of the s should be considered at v body weight and increased ent needs related to medical				
	"Nursing service	00, entitled supplements read, record intake of supplement" ntake of supplement will be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00429	B. WING		06/17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN	FNORTHEAST 55976	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
2 965	Continued From pa	ige 25	2 965		
	registered dietician responsible for resi need to monitor and by the dietician and	THOD OF CORRECTION: The could in-service employees dent nutritional needs on the d follow interventions advised the doctor to maintain weight oss. Then to monitor staff for			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375		7/17/15
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on observati review the facility fa equipment was disi bactericide sanitize directions for a gluo residents (R29, R1 observed. In additi containment of use	ent is not met as evidenced ion, interview and document ailed to ensure glucometer infected according to the r wipe manufacturers cometer used for 3 of 4 1 & R24) glucose tests on the facility failed to ensure d incontinent products and event the spread of infection several residents.		See POC for F441	
	Findings include:				
		cose testing done on 6/10/15 at d nurse (RN)-B was observed			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00429	B. WING			17/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From pa	age 26	21375			
	monitoring, RN-B w seconds with the S stated, "I guess we the manufacturers	After completion of the viped the glucometer for 20 super Sani-Cloth wipe. RN-B e wipe it a while." However, directions say to allow the fected to remain wet for a" full				
6/ (L glu ca sta to of Sa ren on to dia co dia dia co dia to glu co fin fin of	R11 was observed to have glucose test done on 6/10/15 at 6:20 p.m. licensed practical nurse (LPN)-A perform glucose monitoring for R11. The glucometer was removed from the medication cart and taken directly into R11's room. LPN-A stated the facility and not the resident owned and maintained the monitors. When LPN-A returned to the medication cart following the performance of the glucose testing, She used the PDI Super Sani-Cloth wipe to clean the meter. The wipe remained in contact with the meter for less than one minute and the damp monitor was placed on top of the medication cart. LPN-A stated that she did not know how long to keep the disinfectant in contact with the meter. Again the manufacturers directions say to allow the surface to be disinfected to remain wet for a" full 2 minutes." R24 had just completed glucose test on 6/10/15 at 6:30 p.m. LPN-B was observed to clean the glucometer after use. LPN-B used the PDI Super Sani Cloth wipe and left the wipe in contact with the monitor for less than one minute. When finished LPN-B placed the damp monitor on top of the narcotic book. LPN-B stated the disinfectant wipe needed to be in contact with the monitor for 10 to 15 second. Again the		r			
	monitor for 10 to 15 manufacturers dire					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING	B. WING		17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 27	21375			
	meter, wipe down t registered and app	Disinfect read, "To disinfect the he meter with an EPA roved premoistened the product label instructions to				
	The director of nursing was interviewed on 6/10/15 at 9:57 a.m. and stated staff need to follow the directions on the PDI package to disinfect the glucometer. LACK OF PROPER DISPOSAL OF SOILED PADS AND GLOVES TO PREVENT THE SPREAD OF INFECTIONS: During an observation on 6/8/15, at 6:18 p.m. a soiled incontinent pad and gloves were laying on the bathroom floor between resident rooms number 39 and 40. During an interview on 6/8/15, at 6:22 p.m. licensed practical nurse (LPN)-B verified the soiled incontinent product on the floor. LPN-B stated should have not been left on the floor, LPN-B donned gloves and placed the incontinent pad in the garbage bag and removed from room. An undated facility policy AM Cares (Early Morning Care) read, "Leave bedside area clean, and dispose of disposable equipment and soiled linen appropriately." An undated facility policy P.M. Care (Bedtime Care) read, Leave room clean and tidy." An undated facility policy Incontinence Care Guidelines instructed, "Discard disposable items in a plastic trash bag and secure."					
	administrator, direct consulting pharmace policies and procect glucometer meters	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for infection control of . Housekeeping staff could be sary to the importance of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ge 28	21375			
	The administrator a	ocedures of waste materials. and housekeeping director t areas on a regular basis to ce.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			7/27/15
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance mation of the guidelines.				
	by: Based on interview facility failed to ens	ne nursing home. ent is not met as evidenced and document review, the ure all employees received is (TB) training for 6 of 50		See POC for F497		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 29	21426			
	EE-DD, EE-FF, EE	t employees (EE-AA, EE-CC, -HH, EE-LL). In addition the iin annual TB training.				
	Findings include:					
	Program was provi Healthcare Acaden used and offered to work by the employ In-service TB [tube also "Client Behavi Client" must be cor	itled Employee In-Service ded. The procedure indicated ny eLearning services was be completed at home or at yee. The procedure read, "J. rculosis] it's a Cough Away" or" and "Caring for Alzheimer's mpleted before starting work." nclude the staff were to be annual training for				
	6/16/15 at 12:45 p.	MR)-A was interviewed on m. and had provided hours of related to TB for all				
		ere provided for 50 nursing e staff records had not received follows:	1			
	6/18/12 EE-CC was hired a 10/6/92 EE-DD was hired a EE=FF was hired a EE-HH was hired a (LPN) on 4/7/98	s a registered nurse (RN) on as a nursing assistant (NA) on as an RN on 9/29/09 as a NA on 6/15/11 as a licensed practical nurse as an NA on 5/15/96				
	2014 and 2015. Th	tment staff had been hired in ne Orientation Program t related to TB, however, these				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00429	B. WING	B. WING		17/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET I TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 30	21426			
	Cough Away" traini policy/procedure as EE-GG was hired as EE-JJ was hired as EE-kk was hired as EE-NN was hired as EE-NN was hired a EE-OO was hired a EE-PP was hired a EE-PP was hired a EE-II was hired as The assistant direct interviewed on 6/10 she was responsible had missed these r SUGGESTED MET medical director or in-service staff resp most current MDH nursing home. Also	as a NA on 6/17/14 s an RN on 9/9/14 s an NA on 11/25/14 as an NA on 11/12/14 as an NA on 3/25/15 as an NA on 4/28/15 s an NA on 8/11/14 as an NA on 5/12/15				
21495		5 Subp. 5 Social Services; ervices	21495			7/27/15
	services must be p identified social ser according to the co assessment and co	g social services. Social rovided on the basis of rvice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.				
	This MN Requirem	ent is not met as evidenced				

MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOURTH STREET NORTHEAST STEWARTVILLE, NN 55976 OUT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) MAI ID TAG SUMMARY STATEMENT OF DEFICENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21495 Continued From page 31 21495 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. See POC for F247 and F250 Findings include: R26 was admitted to the facility on 4/29/14 according to the facility and ISS of B8 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, 48:26 a.m. in an answer to the question "Have there been any concerns or problems with R1 (R1's quarterly MDS dated 4/8/15, shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her noommate (R68 who had moderate cognitive impairment according to the See POC		(X3) DATE S COMPL	LE CONSTRUCTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T OF DEFICIENCIES OF CORRECTION		
BY EVARUATE CARE CENTER 120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976 CMAID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY AUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY AUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY AUST BE PRECEDED BY FULL TAG 21495 Continued From page 31 21495 See POC for F247 and F250 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/15/15, at 8:26 a.m. in an answer to the question "Have there been any concerns or problems with a roommate or any other resident, "R26 stated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that he noommate (R68 who had moderate cognitive impairment acco	7/2015	06/1		B. WING	00429			
Stewartville, MN 55976 (X4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDE DB V FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG D PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDE DB VF ULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21495 Continued From page 31 21495 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met whem R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. See POC for F247 and F250 Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any concerns or problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that he nad problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the			STATE, ZIP CODE	DRESS, CITY,	STREET AL	ROVIDER OR SUPPLIER	IAME OF F	
IXA (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OF CORRECTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY) 21495 Continued From page 31 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. See POC for F247 and F250 Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with a crommate or any other resident, "R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/8/15 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the					FB	TVILLE CARE CENT	TEWAR	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21495 Continued From page 31 21495 by: Based on observation, interview, and record review the facility failed to ensure 1 of 1 resident (R26) psychosocial needs were met when R26 reported ongoing concerns with roommate (R68) and neighbor resident (R1) that had not resolved and resulted in modification of R26's daily routines to avoid confrontation. Also R68 and R1 had not had interventions developed in regards to behaviors towards R26. See POC for F247 and F250 Findings include: R26 was admitted to the facility on 4/29/14 according to the facility admission record. R26's quarterly Minimum Data Set (MDS) dated 4/15/15 indicated no cognitive impairment and was independent with activities of daily living. During an interview on 6/9/15, at 8:26 a.m. in an answer to the question "Have there been any concerns or problems with a roommate or any other resident," R26 stated, "Yes.!" R26 went on to say that she had problems with R1 (R1's quarterly MDS dated 4/415 shows no cognitive impairment) who lived in the adjacent room and shared the same bathroom as R26. R26 went on to say that her roommate (R68 who had moderate cognitive impairment according to the	(X5)		PROVIDER'S PLAN OF CORF	-	TEMENT OF DEFICIENCIES	(,)		
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quarterly MDS dated 5/6/15). R26 stated R1 had yelled and cursed at her on multiple occasions over the past months and kept R26's bathroom door locked so she had to go into the other residents room to unlock it to use on several occasions. R26 then said her roommate (R68) daily told her when to go to bed, when she could watch television, where to put her walker, and when and how to get dressed. R26 stated R68 seemed to want more space in the shared room for her things. In response to the question, "How does that make you feel to have someone telling					cility admission record. imum Data Set (MDS) dated o cognitive impairment and ith activities of daily living. on 6/9/15, at 8:26 a.m. in an tion "Have there been any ms with a roommate or any 5 stated, "Yes.!" R26 went on problems with R1 (R1's d 4/8/15 shows no cognitive red in the adjacent room and athroom as R26. R26 went on nmate (R68 who had impairment according to the d 5/6/15). R26 stated R1 had ther on multiple occasions ns and kept R26's bathroom had to go into the other nlock it to use on several n said her roommate (R68) to go to bed, when she could here to put her walker, and et dressed. R26 stated R68 ore space in the shared room sponse to the question, "How	R26 was admitted to according to the fact R26's quarterly Min 4/15/15 indicated no was independent we During an interview answer to the quest concerns or problet other resident," R20 to say that she had quarterly MDS date impairment) who live shared the same be to say that her room moderate cognitive quarterly MDS date yelled and cursed at over the past month door locked so she residents room to u occasions. R26 the daily told her when watch television, we when and how to g seemed to want motion for her things. In re		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		06/17/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
STEWAR	RTVILLE CARE CENT	FR					
(X4) ID	SUMMARY ST		TVILLE, MN 5	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	COMPLET DATE	
21495	Continued From pa	age 32	21495				
	her, she's always to reported it to the so concerns, I'm not s is still hereI'm not my concerns. They less just got used to anything more." R2 very loud at night a stated she did not to had been treated (i R68) and was not e because nothing ha help from the facilit not to deal with it, F with it. During a follow up i p.m. R26 indicated well with problems roommate (R68) an me now It still hun frustrated, I'm not a to the question, "He stated, "When [R68 know what I did, bu dealt with the neigh a bedside commod confrontation with. preferred to use the commode. R26 sta bit without one of th am doing." R26 sta change several mo worker had not even stated, "I am tired nothing changes, s learned to deal with R26's care plan pro- read, "Has occasio	R26 stated she would e bathroom vs. the bed side ted, "I can't even move a little nem questioning me on what I ated she had asked for a room onths ago, stated the social er come in to talk with her. R26 of reporting the concerns and o what's the point? I've just					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00429	B. WING		06/	06/17/2015	
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
TEWAF	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE	
21495	Continued From pa	ige 33	21495				
	support with is as n included intervention to resident and end concerns and feelin explanation of diffic resolve the concern Social service prog "[R26] came to soc on 12/5/14 seeking other residents. Sh particularly cruel or that hurt was comp whom she has prev relationship with, al has been also mak past monthshe h often but that apper for her. She is adju avoid confrontation place in the hallway with the supervisor pros and cons of a advised to speak w thoughts on the inter place." The progress services would con support and indicat social worker would R1's progress note of follow-up perform R26 shared with so care plan read, "Do argumentative disp residents. She has other" The care p confrontational with multiple room chan	ress note dated 12/5/14 read, ial work office late in the day support due to conflicts with e describes one resident being an ongoing basis and said ounded when her roommate, <i>v</i> iously shared a good igned with the other party and ing hurtful remarks over the las tried to speak back more ars to be making things worse sting her bathroom routines to The comments also take <i>v</i> s and dining room. I spoke s about the situation and the room change and was ith roommate to ascertain her eractions reported to be taken as note further indicated social tinue to offer emotional ed if problem persisted the d attempt mediation. s were reviewed, no evidence ned related to the concerns of total worker on 12/5/14. R1's	3				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_			
00429			B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
21495	Continued From pa	age 34	21495			
	of follow-up perform R26. R68's care pla concerns, intervent roommate. R26's progress not monitoring had bee voiced concerns at further mention of t the resident brough again in her care co Care conference pur read, "We provided about her interaction next door neighbor issues. She reports same but she had g She tends to accom spoken up." No follow-up was e medical record as a concerns and issue conference. During an interview licensed social wor staff reported to he to the residents and going on" however, aware of the conce documented in the the facility had turn the last year. LSW had been assigned LSW stated a griev	rogress note dated 4/29/15 I [R26] the opportunity to vent ons with her roommate and , mainly bathroom sharing s that these issues remain the grown to better deal with them. nmodate others but also has vident in R26's, R1's, or R68's a result of the again mentioned es at the 4/29/15 care on 6/9/15, at 3:30 p.m. ker (LSW) explained nursing r with any concerns pertaining d "every morning I see what is , LSW stated she was not rns despite the concerns medical record. LSW stated ed over three social workers in stated the social worker who to that wing, left in May 2015. vance had not been filed.				
	director of nursing not been filed. DON have been filled out	r on 6/9/15, at 4:00 p.m. (DON) stated a grievance had N stated a grievance should t in regards to R26's concern 8) and neighbor (R1). Stated				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
			-	B. WING			
		00429			06/	17/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
TEWAR	TVILLE CARE CENT	FR	IRTH STREET RTVILLE, MN 성				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLE DATE	
21495	Continued From pa	age 35	21495				
		the concerns documented in					
		. DON stated the concerns					
		followed up on. DON indicated uld have been re-evaluation of					
		ssible room change and social					
	worker involvemen	t.					
		v on 6/10/15, at 2:08 p.m.,					
		-A indicated awareness of ghbor problems. Stated the					
		ays been complaining and					
		o do, "[R68] tells her to turn the	e				
	TV off, when to go	to bed, and where to put					
		R68] is always saying smart					
		ngs to [R26]. [R26] says she					
		en to her. She [R26] seems /eryday there is something.					
		e expresses frustration with					
		aven't noticed a big change is					
		do know she is frustrated." F-A	A				
		n notified by the facility of the					
		ncerning the roommate or the					
		ained had offered assistance to to the total to the total					
		ems. To the question, "Do you					
		y?" F-A stated, "No, I don't					
		I would think if those people					
		ne would have a better quality					
		ever a person who let people					
		oset about something. She will al with it until it explodes, takes					
		reports anything. She doesn't					
		es, she wants to just do her					
	thing and mind her	own business."					
		v on 6/11/15, at 2:32 p.m.,					
		NA)-K stated R1 tends to be					
		ble and had been aware of Incerns related to R1 locking					
		annot enter from her room.					
		knowledge of the issues with					
		68] is always arguing about the				1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
	0. 00	A. BUILDING:				
		00429	B. WING		06/	17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	NORTHEAST 55976		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21495	Continued From pa	age 36	21495			
		room in half] of where things				
		some issues with the curtains. the curtains too far." NA-K				
	explained R26 was	not the type of person to voice				
		uld wait and wait until it's really ned when there had been				
	resident concerns, they would be reported to					
	social worker. During an interview on 6/11/15, at 2:46 p.m.,					
		<i>i</i> on 6/11/15, at 2:46 p.m., nurse (LPN)-J stated she had				
	•	the concerns with the				
	roommate despite	the concerns documented in				
		. LPN-J stated, "Everybody				
		ole bathroom thing, [R1] made ew about it." LPN-J stated a				
		n placed in R26's as a				
	compromise to the	bathroom problem with R1.				
		/ on 6/11/15, at 3:13 p.m.,				
	NA-E stated "[R1] t	nds to pick on people that are				
		ableshe really goes after				
	[R26] about the bat	throomand is very vocal				
		e know." NA-E stated, "[R68]				
		ain way even if it's on [R26's] shrug it off and ignore it. I have				
		and frustrated. She's the type				
	of person that hold	s things in. She is the type that				
		ith everyone, she is quiet and				
		NA-E explained an example, empted to take R26's calendar				
	down and had to be					
	During an interview	/ on 6/11/15, at 3:35 p.m.,				
		itnessed arguments between				
		past. Stated everybody knew h R1 not wanting to share the				
	bathroom with R26					
	An undated policy e	entitled filing				
		ints indicated "Grievances				
		may be submitted orally or in in in instrator has delegated the				
nesota Di	epartment of Health	mentator nas delegated the	I			<u> </u>

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN	NORTHEAST		
(X4) ID	SUMMABY STA			PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLET DATE
21495	Continued From pa	ge 37	21495			
	investigation to Soc a grievance and/or investigate the alleg report of such findin (5) working days of and/or complaint. An undated facility Clinical Record rea Records of each re about personal and related to the reside	evance and/or complaint sial Services." Upon receipt of complaint, Social Services wil gation and submit a written ng to the administrator within receiving the grievance policy entitled Content Of The d, "Records of Social Service. sident's pertinent social data family problems medically ent's illness and care and of et these needs, will be entered d."				
	The director of nurs ensure arrangemen residents with medi services related to	HOD OF CORRECTION: sing and social worker could nts were made to provide ically necessary social roommate issues and resident tations in the facility.	:			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21610	MN Rule 4658.134 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			7/17/15
	must store all drugs under proper tempe	e of drugs. A nursing home s in locked compartments erature controls, and permit sing personnel to have				
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure safe and secure disposal opical narcotic analgesic		See POC for F431		

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
STEWA	RTVILLE CARE CENTI	-B	RTH STREET TVILLE, MN १			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21610	medication) patches accepted principles for 2 of 2 residents prescribed Fentany that were outdated accidental use and open date to detern outdated this had the residents including R10, & R71) who up prescription medical Findings include: R7's admission recordiagnosis including sensation with pain R7's physician order order for Fentanyl p be applied transder hours, with special and change patch of pain. **When remore and flush down toile R7's Fentanyl patch and stored in the W R55's admission re diagnosis including R55's physician order order for Fentanyl p transdermal every 7 instruction, "When the tissue and flush down container.**" R55's	s according to currently to prevent potential diversion (R7 & R55)reviewed with I patches. Also medications were not removed to prevent medications opened lacked nine when it would be ne potential to affect several (R29, R4, R65, R42, R46, utilized stock medications and tions.	21610			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FB	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 39	21610			
	trained medical ass policy when remove patches, was for twe destruction by puttic container attached both to initial on the Record (MAR). During an observation medication administ medication cart, the container attached unlocked and could the content in the secontainer was easi compartment by secont pieces of o	v on 6/8/15, at 7:15 p.m., sistant (TMA)-A indicated the ing and disposing of Fentanyl vo staff to witness the ing them in the sharps to the medication cart, and for e Medication Administration tion on 6/10/15, at 8:40 a.m., o stration from the West e locking door on the sharps to the cart was observed to be d easily be opened, exposing sharps container. The sharps ly removed from the iding it forward and removing door to the compartment had old tape on the front and ape on the right side of the	f			
	at 8:50 a.m., the E container compartr unlocked and could the sharps contain easily removed fro forward. Licensed	medication storage on 6/10/15 ast medication cart sharps ment door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding i practical nurse (LPN)-A verified sked and the sharps container	t			
	at 8:55 a.m., the N container compartr unlocked and could the sharps contain easily removed fro forward. Registered	medication storage on 6/10/15 orth medication cart sharps ment door, was noted to be d easily be opened, exposing er. The sharps container was m the compartment by sliding i d nurse (RN)-B verified the I and the sharps container				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		-D 120 FOU	RTH STREET	NORTHEAST		
SIEWAF	RTVILLE CARE CENT	ER STEWAR	TVILLE, MN	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21610	Continued From pa	age 40	21610			
	could be removed.					
		medication storage on 6/10/15 wer level medication cart	3			
		ompartment door was noted to				
		ould easily be opened,				
		s container. The sharps				
		ly removed from the ding it forward. LPN-L verified				
		ked and stated, "The door				
	should be locked."					
	During on interview	(0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0				
		v on 6/10/15, at 9:15 a.m., n removing Fentanyl patches				
		for disposal , the policy was for	-			
		the destruction of the patch,				
		ne patch in the sewer system				
		ed patch in the sharps tated, "I always put it in the				
		pointing to the sharps				
	container attached	to the side of the West				
		hen asked about the door to				
		er compartment being ase of removing the sharps				
		erified the door was unlocked				
		se a key to lock it, but was				
		ked. LPN-B stated, "This key				
	fits, but doesn't turr	n to lock the door."				
	During an interview	/ on 6/10/15, at 10:05 a.m.,				
		(DON) stated he was aware				
		tainer compartments were				
		ed during observation, and				
		ld be locked." DON verified the the compartments holding the				
		allowed access to the sharps				
	containers where u	sed Fentanyl patches were				
		had the potential for diversion.				
		would be ordering a new door ation cart because the door				
	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	IRTH STREET RTVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
21610	Continued From pa	age 41	21610			
	was cracked, and t	he doors were to be locked.				
	secure disposal of provided. A memo NURSES," dated 1 directed staff to add wrap in tissue and	sted for ensuring safe and Fentanyl patches, and was no written by DON, to "ALL 2/16/13, was provided, and d, "When removing old patch, flush down toilet or put in when receiving Fentanyl patch				
	administrator, direct consulting pharmace policies and procect medications. The D	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for proper storage of DON or designee, along with uld audit medications on a sure compliance.	9			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			7/16/15
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written be and repair program.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure a safe nment free from rust and paint		See POC for F465		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAF		FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21685	Continued From pa	ge 42	21685				
	(R95, R96, R75, R8 grout around a toile	door frames for 4 of 4 resident 37) rooms and in addition the at used by R11 was soiled and d by (R1) was soiled.					
	Findings include:						
	06/11/2015 at 10:14	nental facility tour on 4 a.m. with maintenance ne following was observed.					
	floor, and the light s chipped paint exposi- colored. The heat is chipped paint. MM painting, the area a	throom door jam near the witch in the bathroom had sing the metal which was rusty register in her room also had -A stated the door jams need round the light switch and the sty and need painting.					
	the light switch had	hroom door jams and around paint chipped and were rusty. ho said he will paint.					
		r frame the paint was chipped. e chipped area's and the need reas.					
		or frame near the bottom was ified the chipped paint on the					
	chair had a thick lay dust/soiled areas. been a long time si cleaned. He said th the wheelchair to hi	s soiled, the poles under the yer of dust, MM-A verified the MM-A stated I suppose its nce the wheelchair was ne process is the staff bring is office with a note asking sh it. MM-A stated they don't					
	keep track of which	wheelchairs are washed and dule for cleaning wheelchairs.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		00429			06/	17/2015	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
TEWAR	TVILLE CARE CENT	FB 120 FOU	RTH STREET	NORTHEAST			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLE DATE	
21685	Continued From pa	age 43	21685				
	jam. The toilet's ca was a yellowish dis the toilet. The bath smell. MM-A agree was yellow and the	room had scratched up door ulking was yellow and there scoloration on the floor around proom had a strong, old urine ed that the caulk and flooring bathroom smelled like urine.					
	director of nursing were suppose to be	(11/2015 at 10:54 a.m. the (DON) said the wheelchairs e on a cleaning schedule and of the lack of wheelchair					
		icy in regards to general ere requested but not received.					
	The administrator, designee could wo maintenance to de to ensure damaged bedroom and bath managed/repaired homelike environm could educate all a	to maintain a safe, clean, ent. The DON or designee ppropriate staff on the d develop monitoring systems					
	TIME PERIOD FO Twenty-One (21) D						
21880	MN St. Statute 144 Residents of HC F	.651 Subd. 20 Patients & ac.Bill of Rights	21880			7/16/15	
	shall be encourage their stay in a facili	nces. Patients and residents ed and assisted, throughout ty or their course of treatment, exercise their rights as					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/17/2015		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		120 EOU	RTH STREET				
		SIEWAH	TVILLE, MN (55976		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21880	Continued From pa	age 44	21880				
	residents may voic changes in policies and others of their interference, coerc including threat of of grievance procedur well as addresses Office of Health Fa nursing home omb Americans Act, sec posted in a conspic Every acute care residential program 253C.01, every non facility employing n provides outpatient have a written inte at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pri an impartial decisio otherwise resolved residential program 253C.01 which are treatment program centers with section health maintenance 62D.11 is deemed	, and citizens. Patients and e grievances and recommend s and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older ction 307(a)(12) shall be cuous place. e inpatient facility, every m as defined in section nacute care facility, and every nore than two people that t mental health services shall ernal grievance procedure that, s forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written ovides for a timely decision by on maker if the grievance is not l. Compliance by hospitals, ms as defined in section e hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance					
nesota D ATE FORI	epartment of Health		6899	EHX11	lf continuati		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
STEWAR	TVILLE CARE CENT	FB	RTH STREE [.] TVILLE, MN	FNORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21880	Continued From pa	age 45	21880			
	by: Based on observat review, the facility f grievances were re	ent is not met as evidenced ion, interview and document ailed to ensure resident solved promptly for 4 of 4 6, R7 & R66) who expressed a cility staff.		See POC for F166		
	Findings include:					
	p.m. R53 reported long. R53 stated, "S night. I've told all th I've asked if they ca nothing happens. T	with R53 on 6/8/15, at 6:05 her roommate hollers all night She sleeps all day, hollers all he nurses. Nothing gets done. an give her a private room, but They try different stuff, it keeps me up all night. They or me."				
	5/3/15, at 1:39 a.m "can't sleep with he from 5/3/15 at 1:46 on ss [social servic that incident." On 5 note entry included was doing over by	R53's medical record dated . indicated R53 had reported, er hollering." Another note a.m. indicated, "message left es] telephone in regards to 5/3/15 at 5:13 a.m. a nurse's , "asked her [R53] what she [R30's] bed during the night was giving her a stuffed he wouldn't holler"				
		imum Data Set (MDS) dated ntact cognition with no nunication issues.				
		with R46 on 6/9/15, at 09:23 different times someone e up at night."				
incosto D		nedical record dated 5/16/15, ed, "States she can't sleep				
TE FOR	-		6899	LEHX11	If continuation	n sheet 46

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 46	21880			
	her awake which u	cause her roommate keeps sually sets off the alarm and vous Message left for SS."				
	4/29/15, indicated t	num Data Set (MDS) dated he resident had intact ehavioral or communication				
	p.m. R7 stated, "we	v with R7 on 6/8/15, at 6:36 e have a person (R30) next re she goes to bed."				
	p.m. R7 said she h of nursing (DON) a night, so the DON	with R7 on 6/11/15, at 3:40 ad complained to the director bout the noise R30 made at had moved R30 to another ow in the room next to me."				
		lated 3/31/15, identified R7 with no behavioral or ues.				
		v with R66 on 6/8/15, at 06:44 s noisy because another lady is t at night."	\$			
		S dated 4/22/15, identified the tively intact with no behavioral ssues.				
	on 6/11/15 at 2:32	v with nursing assistant (NA)-D p.m., NA-D said, "I have heard night from the night staff."				
	licensed practical r a problem yelling a try to medicate her	on 6/11/15, at 2:41 p.m. hurse (LPN)-J said, "(R30) has nd cries at night. The staff will and sit with her. This couple times a week. Her				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN &				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 47	21880				
	night. Everybody is	d she (R30) has kept her up all s aware of it, social services f nursing (DON). I don't know					
	9:55 a.m., LPN-K s but it has been a p night. She cries ou noise, about 1-2 tin	with LPN-K on 6/12/15 at stated, "(R30) slept last night roblem with her yelling in the ut at night or at least makes nes a week. SS and the DON is a difficult issue to resolve."					
	p.m., SS-A stated, grievances for the about (R30) crying grievance form abo grievance form on residents to use the	with SS-A on 6/11/15 at 2:56 "I don't have any written past six months. I have heard out but I have not gotten a but it. Everyone is given a admission. We do not remind e grievance form. The staff try as fast as they can but she stil ut."					
	DON said he was r people awake at ni aware of the daytin	v on 6/11/15 at 5:24 p.m., the not aware [R30] was keeping ght but acknowledged, "I was ne noises." The DON stated he e process needed to be					
	Grievances/Compl and/or complaints writingthe admini responsibility of gri investigation to Soc grievance and/or co investigate the aller report of such findi	policy entitled, Filing aints indicated: "Grievances may be submitted orally or in strator has delegated the evance and/or complaint cial Services. Upon receipt of a omplaint, Social Services will gation and submit a written ng to the administrator within f receiving the grievance	L				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21880	Continued From pa	age 48	21880				
	director of nursing requirement to add make a good faith complaint/concern.	THOD OF CORRECTION: The could in-service staff on the ress resident concerns and attempt to resolve the R CORRECTION: Twenty-one					
	(21) days.						
21980	MN St. Statute 626 Maltreatment of Vu	557 Subd. 3 Reporting - Inerable Adults	21980			7/16/15	
	reporter who has re vulnerable adult is or who has knowled has sustained a ph reasonably explain information to the c individual is a vulne the individual is adu reporter is not requ	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated irred to report suspected e individual that occurred prior ss:					
	another facility and believe the vulnera previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte	knows or has reason to believe s a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the section may voluntarily report					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 49	21980			
	reporter from also agency. (e) A mandated reason to believe the 626.5572, subdivis (5), occurred must subdivision. If the time believes that a agency will determ the reported error of the criteria under s 17, paragraph (c), facility may provide directly to the lead how the event mee 626.5572, subdivis (5). The lead agen	is section shall preclude a reporting to a law enforcement reporter who knows or has hat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ets the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of ubdivision 9c.				
	by: Based on observat review, the facility f allegations of maltr point (CEP) for 5 o	ent is not met as evidenced ion, interview and document failed to immediately report reatment to the common entry f 6 residents (R75, R65. R64, ewed for allegations of		See POC for F490		
	Although R75 was at by licensed prac following the supper subsequently obse physically abusive	observed by staff to be yelled tical nurse (LPN)-E on 4/24/15 er meal, and LPN-E was rved to be verbally and to R65 that same evening, ents were not immediately				

STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		00429	B. WING		06/17/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
STEWAR	TVILLE CARE CENT	FR						
		ATEMENT OF DEFICIENCIES	TVILLE, MN १	PROVIDER'S PLAN OF	CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21980	Continued From pa	age 50	21980					
		State agency, nor were ed to prevent further abuse.						
	REGARDING an E completed by nursi 4/25/15. The conce NAME: [LPN-E's fin CONCERN: Upon residents from sup heard a lot of comm that the nurse [LPN at resident [R75]. V her room, she [R75] question and he sta	INT/CONCERN FORM IMPLOYEE had been ing assistant (NA)-C dated ern included: "EMPLOYEE rst name] "COMPLAINT OR returning from bringing per co-worker [NA-E] and I notion/screaming. We noticed Ve tried to take her [R75] to 5] asked [LPN-E] another arted yelling at her again. moved her [R75] from the						
	5/12/15 indicated F mental status (BIM R75 was severely of	nimum data set (MDS) dated R75 had a brief interview for IS) score of 4 which indicated cognitively impaired. The MDS could hear with minimal						
	9:51 a.m., R75 was with family (F)-A. F the surveyor without	v and observations on 6/9/15 a s observed during an interview R75 conversed with F-A and ut hearing difficulty and ave to speak loudly for resident						
	careful, explanation	ected staff to provide, "Clear, ns to facilitate her epeat/rephrase words as hearing and comprehension."						
	investigation of the	ed by the DON related to the se incidents, included a typed d 4/25/15 at 10:00 a.m., by the						

Minnesc	ota Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	FR	RTH STREET TVILLE, MN 성	NORTHEAST 55976		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	· · · ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
21980	Continued From pa	age 51	21980			
	included, "Spoke to Friday 4-24-15 p.m was talking to [R75 questions and as [L questions he was b yelling, and was pro should. [R65] was s walker but did not s (NA-L) heard a little (certified nursing as	he interview documentation o [NA-L] concerning incident . shift. She stated he [LPN-E]]. [R75] was repeating _PN-E] was answering becoming more upset and obably yelling more than he standing nearby with her say anything. Stated she e later from another CNA ssistant) that [R65] was hitting a attempting to hit them with				
		ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the acility.				
	DON was asked to regarding the imme allegations of abuse residents to the adr and any interventio other residents, or a incident. The DON the allegation involve because he had be	on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the e between LPN-E and the ministrator or State agency, ns taken to protect R75 or any investigation of the abuse confirmed he had not reported ving R75 to the State agency en more focused on the gation between LPN-E and				
linnesota D	REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch	AINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med PN-E]. She [R65] attempted to ner and he [LPN-E] grabbed e a choke hold. I attempted to				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	FB	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	age 52	21980				
] went over and intervened. I nt [R65] down afterwards but d up."					
	regards to when he incident with R65 w evening meal, DON phone message or incident but he did morning (Saturday come to the facility The DON stated it director of nursing, administrator, or so	on 6/11/15, at 9:34 a.m. in a was notified of the abuse which occurred on 4/24/15 after N stated staff had placed a his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, ocial worker to submit any re reports to the State					
	reporting of these a verbal/physical abut the State agency (0 abuse R75 had sus was made on 6/12/ plan of correction for been informed that situation existed. T the State agency in [Minnesota Departh to this writer's atter [LPN-E] was yelling was initially reporte another demented the main focus of th information in rega- investigation of R65 was also agitated a	eyor's inquiry about the alleged incidents of ise, the DON made a report to DHFC) regarding the verbal stained on 4/24/15. The report (15, as part of the immediate ollowing the facility having an immediate jeopardy he incident description sent to included: "During routine MDH ment of Health], it was brought of the ant on 4/24/15, staff LPN g at resident [R75]. An incident d on 4/25/15 regarding resident [however, R65 was nat OHFC report and rds to R75 was to support the 5. During this incident [R75] and following the nurse and not rection. Nurse [LPN-E] did yell					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
STEWAF	RTVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21980	Continued From pa	ige 53	21980				
	initially combined b nurse [LPN-E] into	nued agitation. This writer oth of these actions by the one investigation and I am particular situation as a ."					
	The undated policy entitled Reporting Abuse to State Agencies and Other Entities/Individuals included, "All alleged/suspected violations and all substantiated incidents of abuse will be reported immediately to the Administrator and promptly reported to appropriate State agencies."						
	agency on 4/16/15, witnessed R64 beir (F)-B on 4/15/15, a indicated, "[R64] w next to [F-B]As he	omitted a report to the state indicating a nurse had ng hit on the forearm by family round 4:40 p.m. The report vas sitting in a reclining chair e was attempting to get up and B] struck him on the					
	admission record d with functional decl quarterly Minimum 3/25/15, identified F impairment and rec	ccording to the resident ated 1/21/15, included debility ine and dementia. The Data Set (MDS) dated R64 had severe cognitive quired extensive assistance r all activities of daily living					
	4/15/15, included a observed resident a recliner chair. [F-B] back down. Nurse voice. Nurse then c	sing progress notes dated note from 4:30 p.m., "Nurse attempting to get out of a attempted to tell resident to si noted agitation in the [F-B ' s] observed resident's [F-B] pull t of resident's hand and hit	t				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN १				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21980	Continued From pa	age 54	21980				
		earmNurse immediately es to evaluate the situation. ed as well."					
	member striking Re	/ was aware of the family 64 on 4/15/15, the incident was State agency until the next					
	origin on 8/19/14, th	ained an injury of unknown he facility failed to ensure the state agency were notified					
	the State agency of had occurred the provide the provided th	or R99 had been submitted to n 8/20/14 for an incident that revious day, "Res [resident] oom by a CNA [certified nursing residentwas lying on the anding in the room guarding id complain of pain. Res was oncy Room for xray and indicate resident sustained a shoulder"					
	admission record d diagnoses including osteoporosis. The o identified R99 as ha impairment and rec	eviewed. The resident lated 2/26/10, identified g: senile dementia and quarterly MDS dated 8/12/14, aving severe cognitive quiring limited assistance from sferring and walking.					
	8/19/14 at 10:30 a. resident's room and friend was laying or was standing guard her left arm and sa	sing progress notes dated m. included, "CNA entered this d noted that this resident's n the floor and this resident ding her left armShe guards id owe-owe when any attempt DM [range of motion]."					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
STEWAF	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21980	Continued From pa	ge 55	21980				
	Investigation Report administrator and d indicated the incide administrator on "8, reported to the Statt "8/20/14, PM." Although the facility of unknown origin d	lity's Alleged Resident Abuse t Form, signed by the lirector of nursing on 8/20/14, ant had been reported to the /20/14, AM," and had been the licensing agency on was aware R98 had bruising on 8/10/14, the facility failed to					
		trator and state agency were					
	agency on 8/12/14, cares [8/10/14] resi large, purple-black forearm extending finger. Has no histo	mitted a report to the State which included: "During AM dent was discovered to have a bruise on the left medial along the left thumb and index ory of recent trauma, or falls. to say what happened due to e."					
	admission record d resident had diagno Alzheimer's disease 11/18/14, identified	eviewed and the resident ated 12/5/08 indicated the oses including: dementia and e. A quarterly MDS dated R98 had severe cognitive s totally dependent on staff for living.					
	8/10/14 at 12:40 p. cares were being p bruise was noted o extending along the measuring 23.5 cm 4.5 cm in width. Th indicated R98's left	sing progress notes dated m., indicated while morning rovided, a large, purple-black n R98's left medial forearm, e left thumb and index finger, (centimeters) in length, and e progress notes also hand and fingers were e area appeared to be tender,					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/17/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE				
STEWAR	TVILLE CARE CENT	FB	RTH STREET RTVILLE, MN &				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET	
21980	Continued From pa	age 56	21980				
	as R98 cried out w	hen arm was moved.					
	indicated the purpli medial forearm ext	ents Report dated 8/10/14, ish-black bruise on R98's left ending to the side of the thumk ras mildly painful and was	5				
Inve the 8/19 resi trau RO 8-12 com intra inve adm	Investigation Repo the administrator a 8/15/14, included: ' resident's L [left] m trauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impact intra-articular exter investigative report	not been notified of the 8/10/14					
	stated administrative to the State agency them to call me." T cell phone and state reach him, and he the administrator. that were submittee not all been submit administrator or Sta DON confirmed he	n 6/11/15 at 9:34 a.m., the DON ve staff were to submit reports y, "Other staff can, but I want "he DON stated he carried a ff knew they could always would then report incidents to The DON verified the reports d for R64, R99, and R98, had tted immediately to the ate agency as required. The was aware the reports needed mediately and stated, "We blem."					
	Abuse to State Age Entities/Individuals	ity's undated policy Reporting encies and Other included: "Should an violation or substantiated					

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	FR	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21980	Continued From pa	ige 57	21980			
	unknown source, o	ment, neglect, injuries of an r abuse be suspected, it must orted to the administrator and encies."				
	The administrator a abuse prohibition p revise as necessar the policies and pro	THOD OF CORRECTION: and designee could review olicies and procedures and y, could educate all staff on pocedures, and monitor all erable adult reports for porting.				
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			6/17/15
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. Howeve	I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains aplying with the immediate ents of this section.				
	by: Based on observati review, the facility f allegations of maltr Point (CEP) for 5 o	ent is not met as evidenced ion, interview and document ailed to immediately report eatment to the Common Entry f 6 residents (R75, R65. R64, ewed for allegations of		See POC for F223		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00429	B. WING		06/	06/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
STEWAR	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 58	21995				
	Findings include:						
	at by licensed prace following the support subsequently obse physically abusive however, the incide reported to the the interventions initiate A facility COMPLAI REGARDING an E completed by nursi 4/25/15. The conce NAME: [LPN-E's fin CONCERN: Upon residents from sup heard a lot of comment that the nurse [LPN at resident [R75]. Wher room, she [R75] question and he stat That's when we remisituation"	observed by staff to be yelled tical nurse (LPN)-E on 4/24/15 er meal, and LPN-E was rved to be verbally and to R65 that same evening, ents were not immediately State agency, nor were ed to prevent further abuse. NT/CONCERN FORM MPLOYEE had been ng assistant (NA)-C dated ern included: "EMPLOYEE rst name] "COMPLAINT OR returning from bringing per co-worker [NA-E] and I notion/screaming. We noticed J-E] was yelling and screaming Ve tried to take her [R75] to 5] asked [LPN-E] another arted yelling at her again. noved her [R75] from the					
	5/12/15 indicated F mental status (BIM R75 was severely of	himum data set (MDS) dated R75 had a brief interview for S) score of 4 which indicated cognitively impaired. The MDS could hear with minimal					
	9:51 a.m., R75 was with family (F)-A. F the surveyor without	v and observations on 6/9/15 at s observed during an interview R75 conversed with F-A and ut hearing difficulty and ave to speak loudly for resident					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/17/2015	
		00429	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR		NORTHEAST		
		SIEWAR	TVILLE, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 59	21995			
	careful, explanation comprehensionre needed to facilitate Information provide investigation of the interview conducted DON with NA-L. Th included, "Spoke to Friday 4-24-15 p.m was talking to [R75 questions and as [L questions he was by yelling, and was pro should. [R65] was s walker but did not s (NA-L) heard a little (certified nursing as	ected staff to provide, "Clear, ns to facilitate her epeat/rephrase words as hearing and comprehension." ed by the DON related to the se incidents, included a typed d 4/25/15 at 10:00 a.m., by the he interview documentation o [NA-L] concerning incident . shift. She stated he [LPN-E] i]. [R75] was repeating _PN-E] was answering becoming more upset and obably yelling more than he standing nearby with her say anything. Stated she e later from another CNA ssistant) that [R65] was hitting d attempting to hit them with				
		ed on 6/9/15 at 3:45 p.m. to be cation pass on a unit in the acility.				
	DON was asked to regarding the imme allegations of abuse residents to the adr and any interventio other residents, or a	on 6/12/15, at 9:30 a.m., the provide all information ediate reporting of the e between LPN-E and the ministrator or State agency, ns taken to protect R75 or any investigation of the abuse confirmed he had not reported				
	the allegation involved because he had be	ving R75 to the State agency een more focused on the gation between LPN-E and				

Minneso	ota Department of He	ealth			FUNIM	APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
STEWAR	RTVILLE CARE CENT	FR	RTH STREET			
0121174		STEWAR	TVILLE, MN (55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21995	Continued From pa	age 60	21995			
	REGARDING an E NA-C on 4/25/15 al [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitcl her from behind like go over but [LPN-J] tried to calm reside she was too worked	•				
	regards to when he incident with R65 w evening meal, DON phone message on incident but he did morning (Saturday come to the facility The DON stated it director of nursing, administrator, or so	y on 6/11/15, at 9:34 a.m. in e was notified of the abuse which occurred on 4/24/15 after N stated staff had placed a n his home phone following the not listen to it until the next 4/25/15) at which time he had to follow-up on the incident. was the responsibility of the assistant director of nursing, ocial worker to submit any re reports to the State				
	reporting of these a verbal/physical abut the State agency (C abuse R75 had sus was made on 6/12/ plan of correction for been informed that situation existed. T the State agency in [Minnesota Departr	eyor's inquiry about the alleged incidents of use, the DON made a report to DHFC) regarding the verbal stained on 4/24/15. The report (15, as part of the immediate ollowing the facility having an immediate jeopardy he incident description sent to included: "During routine MDH ment of Health], it was brought ation that on 4/24/15, staff LPN				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	4	DDRESS, CITY, ST	TATE, ZIP CODE		
		120 FOU	RTH STREET	NORTHEAST		
IEWAN	TVILLE CARE CENT	STEWAR	RTVILLE, MN 5	5976		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21995	Continued From pa	age 61	21995			
	was initially reported another demented the main focus of t information in rega investigation of R6 was also agitated a responding to re-di at resident due to h [R75] and her cont initially combined b nurse [LPN-E] into	g at resident [R75]. An incident ed on 4/25/15 regarding resident [however, R65 was hat OHFC report and urds to R75 was to support the 5. During this incident [R75] and following the nurse and not irection. Nurse [LPN-E] did yell his frustration with resident inued agitation. This writer both of these actions by the one investigation and I am particular situation as a "	t			
	State Agencies and included, "All allege substantiated incid immediately to the	v entitled Reporting Abuse to d Other Entities/Individuals ed/suspected violations and all lents of abuse will be reported Administrator and promptly riate State agencies."				
	agency on 4/16/15 witnessed R64 bei (F)-B on 4/15/15, a indicated, "[R64] v next to [F-B]As h	omitted a report to the state , indicating a nurse had ng hit on the forearm by family around 4:40 p.m. The report vas sitting in a reclining chair e was attempting to get up and ·B] struck him on the				
	admission record of with functional dec quarterly Minimum 3/25/15, identified impairment and rec	ccording to the resident dated 1/21/15, included debility line and dementia. The Data Set (MDS) dated R64 had severe cognitive quired extensive assistance or all activities of daily living				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		06/	6/17/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-		
STEWAR	TVILLE CARE CENT	FR	RTH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 62	21995				
	 4/15/15, included a observed resident recliner chair. [F-B] back down. Nurse voice. Nurse then of the chair control ou him on the right for called social service. Administrator notific Although the facility member striking R not reported to the day, 4/16/15. Although R99 sust origin on 8/19/14, t administrator and s immediately. An incident report of the State agency of had occurred the p was found in her roassistant]. Another floor[R99] was st her left arm. She d sent to the Emerged 	y was aware of the family 64 on 4/15/15, the incident was State agency until the next ained an injury of unknown he facility failed to ensure the state agency were notified for R99 had been submitted to n 8/20/14 for an incident that previous day, "Res [resident] bom by a CNA [certified nursing residentwas lying on the randing in the room guarding id complain of pain. Res was ency Room for xray and indicate resident sustained a	3				
	admission record of diagnoses includin osteoporosis. The identified R99 as h	eviewed. The resident dated 2/26/10, identified g: senile dementia and quarterly MDS dated 8/12/14, aving severe cognitive quiring limited assistance from					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENTI	-B	RTH STREET TVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21995	Continued From pa	-	21995			
	one person for tran	sferring and walking.				
	8/19/14 at 10:30 a.r resident's room and friend was laying or was standing guard her left arm and sai	sing progress notes dated m. included, "CNA entered this d noted that this resident's in the floor and this resident ling her left armShe guards d owe-owe when any attempt DM [range of motion]."				
	Investigation Repor administrator and d indicated the incide administrator on "8/	ity's Alleged Resident Abuse t Form, signed by the irector of nursing on 8/20/14, nt had been reported to the /20/14, AM," and had been e licensing agency on				
	of unknown origin o	was aware R98 had bruising on 8/10/14, the facility failed to trator and state agency were y.				
	agency on 8/12/14, cares [8/10/14] resi large, purple-black forearm extending a finger. Has no histo	mitted a report to the State which included: "During AM dent was discovered to have a bruise on the left medial along the left thumb and index ry of recent trauma, or falls. to say what happened due to e."				
	admission record d resident had diagno Alzheimer's disease 11/18/14, identified	eviewed and the resident ated 12/5/08 indicated the oses including: dementia and e. A quarterly MDS dated R98 had severe cognitive s totally dependent on staff for living.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED		
		00429	B. WING	B. WING		06/17/2015		
	PROVIDER OR SUPPLIER		DDBESS CITY S	DRESS, CITY, STATE, ZIP CODE				
		120 FOU	RTH STREET					
IEWAH	TVILLE CARE CENT	ER STEWAF	RTVILLE, MN 🖇	55976				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
21995	Continued From pa	age 64	21995					
	8/10/14 at 12:40 p. cares were being p bruise was noted o extending along the measuring 23.5 cm 4.5 cm in width. Th indicated R98's left edematous, and th as R98 cried out w A Skin Integrity Eve	sing progress notes dated m., indicated while morning provided, a large, purple-black on R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and he progress notes also t hand and fingers were e area appeared to be tender, hen arm was moved.						
	medial forearm ext and index finger, w swollen. A review of the faci	ish-black bruise on R98's left ending to the side of the thumb as mildly painful and was ility's Alleged Resident Abuse rt Form, signed as reviewed by						
	the administrator a 8/15/14, included: ' resident's L [left] m trauma to area. Dis ROM. Seen by NP 8-12-14, and x-ray comminuted impact intra-articular exter investigative report	nd director of nursing on "Unexplained bruise noted on edial forearm. No history of scomfort noted with gentle [nurse practitioner] on ordered. Results show a sted fracture distal radius with histon and osteoporosis" The also indicated the not been notified of the 8/10/14						
	stated administrative to the State agency them to call me." T cell phone and state reach him, and he the administrator. that were submitted	n 6/11/15 at 9:34 a.m., the DON ve staff were to submit reports y, "Other staff can, but I want he DON stated he carried a ff knew they could always would then report incidents to The DON verified the reports d for R64, R99, and R98, had tted immediately to the	J					

Minnesc	ta Department of He	alth			FORM	1 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
STEWAF		EB	RTH STREET IVILLE, MN	NORTHEAST 55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 65	21995			
	DON confirmed he	ate agency as required. The was aware the reports needed nediately and stated, "We blem."				
	Abuse to State Age Entities/Individuals alleged/suspected v incident of mistreat unknown source, o	included: "Should an violation or substantiated ment, neglect, injuries of an r abuse be suspected, it must orted to the administrator and				
	The administrator a abuse prohibition p revise as necessary the policies and pro-	HOD OF CORRECTION: and designee could review olicies and procedures and y, could educate all staff on peedures, and monitor all rable adult reports for porting.				
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)				
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			7/16/15
	facility, except hom personal care atten establish and enfor prevention plan. Th assessment of the environment, and it factors which may e and a statement of to minimize the risk	prevention plans. (a) Each e health agencies and dant services providers, shall ce an ongoing written abuse ne plan shall contain an physical plant, its s population identifying encourage or permit abuse, specific measures to be taken c of abuse. The plan shall es governing the plan				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00429	B. WING		- 06/17/2015		
AME OF F	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
TEWAR	TVILLE CARE CENT	FR	RTH STREET I TVILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
22000	Continued From pa	age 66	22000				
	agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ac specific measures risk of abuse to tha	including a home health care al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing lults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the					
	and personal care knows that the vuln violent crime or an toward others, the plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Unc of a vulnerable adu misconduct or phy such information fre authority or through another facility, and	except home health agencies attendant services providers, herable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to hat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows lit's history of criminal sical aggression if it receives om a law enforcement h a medical record prepared by other health care provider, or g assessments of the					
	This MN Requirem	ent is not met as evidenced					

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COM	PLETED
		00429	B. WING		06/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
STEWAF	RTVILLE CARE CENT	FR	RTH STREE [.] TVILLE, MN	F NORTHEAST 55976		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
22000	Continued From pa	ige 67	22000			
	facility failed to imp policies and proced reporting of alleged administrator and S resident/s from ong thorough investigat abuse/neglect for 5 R64, R99, R98) wh prohibition. This ha residents currently Findings include: On 6/11/15 the faci	and document review, the lement their abuse prohibition dures related to immediate l abuse/neglect to the State agency, protecting joing abuse, and completing a ion following an allegation of of 26 residents (R75, R65, o were reviewed for abuse d the potential to affect all 68 residing in the facility.		See POC for F490		
	and Symptoms of A personnel are to re of abuse/neglect to director of nursing s the Administrator." and symptoms of a promptly. The proce	entitled Recognizing Signs abuse/Neglect read, "all port any signs and symptoms their supervisor or to the services and immediately to The procedure directed signs buse should be reported edure lists signs of actual ns of actual physical neglect, as of psychological				
	involving residents of nursing services administrator." Th "all accidents/incide thoroughly investiga	ating Resident s read, "All accidents/incidents must be report to the director and immediately to the e procedure directed staff that ents involving residents will be ated by management and the restigation will be kept on file				

Minnesota Department of Health STATE FORM

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		120 FOU	RTH STREET			
SIEWAF	RTVILLE CARE CENT	ER STEWAR	TVILLE, MN 5	55976		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	ige 68	22000			
	Investigation read, or neglect shall be investigated." The administrator would investigate the incid report daily to the a the investigation. T that employees that resident abuse wou nonresident care du results of the invest the administrator. The undated policy Residents During A facility will protect re investigations of ab procedure directed investigations, emp abuse would be read duties or put on lear reassignments would building which the re procedure read, "SI	entitled Abuse and/or Neglect "All reports of resident abuse promptly and thoroughly procedure directed the d appoint a designee to dent and that person would dministrator the progress of The procedure also directed t had been accused of ald be reassigned to uties or put on leave until the tigation had been reviewed by entitled Protection of buse Investigation read, "Our esidents from harm during buse allegations." The that during abuse loyees accused of resident assigned to nonresident care ve; and that if employees were resident care duties, such not be in any part of the resident frequents. The hould the results indicate that propriate authorities will be				
	State Agencies and	entitled Reporting Abuse to I Other Entities/Individuals uspected violations and all				
	substantiated incide immediately to the	ents of abuse will be reported Administrator and promptly iate state agencies. The				
	alleged/suspected incident of mistreat	violation or substantiated ment, neglect, injuries of r abuse to be suspected. It				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
STEWA	RTVILLE CARE CENT	FR	RTH STREET TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
22000	must be immediate and to proper state Social Services 2. I Health/OHFC. B. M above agencies wil following the incide administrator, or his internal investigatio working days of the R75 was observed by licensed practica The incident was m administrator or de was R75 protected thorough investigation A facility COMPLAI REGARDING an E completed by nursi The concern includ [LPN-E's first name CONCERN: Upon for residents from supple heard a lot of comment that the nurse [LPN at resident [R75]. W her room, she [R75] question and he sta That's when we remisituation" During an interview DON was asked for immediate reporting administrator, OHF protect R75 from fur residents and a tho abuse incident. Not	Ally reported to the administrator agencies 1. Olmsted County Winnesota Department of Verbal/written notices to the I be made immediately nt if possibleC. The s/her designee, will submit on report to OHFC website 5 e occurrence of the incident." to have been verbally abused al nurse (LPN)-E on 4/24/15. ot immediately reported to the signated State agency, nor following this incident, or a		DEFICIENC		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		06/17/2015	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
STEWAF	TVILLE CARE CENT	FR	RTH STREET I			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
22000	Continued From pa	age 70	22000			
	in regards to the ph DON stated he was abuse incident with physical abuse of F verbal abuse of R7 the evening meal a medications. Progress note was record until two day "Several staff mem conference room w voice towards resid indicated notification	with the report sent to OHFC hysical abuse to R65. Then the s more focused on the physical R65 at the time. Again the R65 occurred shortly after the 5 by LPN-E on 4/24/25 after the LPN-E was passing not entered into the medical ys later on 4/27/15 and read, bers were in the south when a staff nurse heard raising lent." The progress note also on of DON, ADON, and Social did not indicate when the				
	notifications were g The DON reported OHFC and to the C 6/12/15 after the su					
	R65 had been verb LPN-E on 4/24/15 l	ally and physically abused by however, this was not ed to the administrator or				
	REGARDING an E NA-C on 4/25/15 at [p.m.] I went to go a and noticed resider cart arguing with [L grab the water pitch her from behind like go over but [LPN-J	AINT/CONCERN FORM MPLOYEE completed by lso included:"Around 7:40 ask nurse [LPN-J] a question nt [R65] standing by the med .PN-E]. She [R65] attempted to her and he [LPN-E] grabbed e a choke hold. I attempted to] went over and intervened. I ent [R65] down afterwards but				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00429	B. WING		06/	06/17/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
STEWAR	TVILLE CARE CENT	FR	RTH STREET TVILLE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 71	22000			
	that occurred on 4/ investigation for Re LPN-J read, "On Fi staff potluck,He medication admin a grabbed the water it. He grabbed it ou on cart. She then ra him with it, not sure dropped it but it fell up and [R65] went fist at which time I g [R65] to leave the a shortly after that." The facility provide submission report fo f Health Facility C investigative notes complaint, the alleg to R65 had not bee had been reported R64 had an allegat family (F) member however, it was not until the next day. The facility submitt on 4/16/15 indicatin being hit on the for around 4:40 p.m. " chair next to [F-A] up and out of the c	count of the physical abuse 24/15 as part of the 35 completed on 4/25/15 by riday 4/24/15 I was here for [LPN-E] was finishing up a at cart when [R65] came up pitcher and tried to hit him with it of her hands and set it back aised up her walker, as if to hit e if he knocked it down or she I on the floor. [LPN-E] picked it as if to hit him with a closed got between them and asked area which she did. [LPN-E] lef d the incident report, to the State agency (the Office omplaints-OHFC), and all . According to the OHFC gation of verbal/physical abuse en not immediately reported but the following day 4/25/15. ion of physical abuse by a which occurred on 4/15/15 t reported to the State agency ed a report to the State agency ng a nurse witnessed R64 earm by [F-A] on 4/15/15, [R64] was sitting in a reclining As he was attempting to get hair, [F-A] struck him on the	t			
anosota D	4/15/15, at 4:30 p.r	sing progress notes, dated n., included, "Nurse observed to get out of a recliner chair.				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00429		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED 06/17/2015	
		B. WING		06/		
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET I TVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pa	age 72	22000			
	[F-A] attempted to tell resident to sit back down. Nurse noted agitation in the [F-A]'s voice. Nurse then observed resident's [F-A] pull the chair control out of resident's hand and hit him on the right forearmNurse immediately called social services to evaluate the situation. Administrator notified as well."					
	causing a fracture	an injury of unknown origin the facility did not immediately to the state agency.				
	agency on 8/20/14 found in her room I assistant]. Another floor [R99] was s her left arm. She d sent to the Emerge	for R99, submitted to the State indicated, "Res [resident] was by a CNA [certified nursing residentwas lying on the standing in the room guarding lid complain of pain. Res was ency Room for xray and indicate resident sustained a shoulder"				
	8/19/14 at 10:30 a. this resident's room friend was laying o was standing guard her left arm and sa	sing progress notes dated .m., included: "CNA entered n and noted that this resident's n the floor and this resident ding her left armShe guards aid owe-owe when any attempt OM [range of motion]."				
	Investigation Repo administrator and c indicated the incide reported to the adm	ility's Alleged Resident Abuse rt Form, signed by the director of nursing on 8/20/14, ent from 8/19/14 had first been ninistrator on "8/20/14, AM," ntly been reported to the State on "8/20/14, PM."				
		have a large bruise on her left s found to be a fracture				

Minnesota Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00429		B. WING		06/17/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEWAR	TVILLE CARE CENT	FR	RTH STREET RTVILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 73	22000			
	State agency or the	not immediately reported to the e administrator as directed by olicy and procedure.	;			
	on 8/12/14, which i [8/10/14] resident w purple-black bruise extending along the Has no history of re	ed a report to the state agency included: "During AM cares was discovered to have a large e on the left medial forearm e left thumb and index finger. ecent trauma, or falls. Resident what happened due to se."	,			
	8/10/14 at 12:40 p. cares were being p bruise was noted o extending along the measuring 23.5 cm 4.5 cm in width. Als and fingers were en	sing progress notes dated m., indicated while morning provided, a large, purple-black on R98's left medial forearm, e left thumb and index finger, n (centimeters) in length, and so included, R98's left hand dematous, and the area ider, as R98 cried out when				
	Investigation Repo administrator and o included: "Unexpla L [left] medial forea area. Discomfort ne motion]. Seen by N 8-12-14, and x-ray comminuted impact intra-articular exter	ility's Alleged Resident Abuse rt Form, signed by the director of nursing on 8/15/14, ined bruise noted on residents arm. No history of trauma to oted with gentle ROM [range o IP [nurse practitioner] on ordered. Results show a cted fracture distal radius with nsion and osteoporosis" Also nistrator was not notified until	f			
	of unknown origin	y was aware R98 had bruising on 8/10/14, the facility failed to strator and State agency were				

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED				
	00429	B. WING		06/1	7/2015			
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
STEWARTVILLE CARE CENT	FR	RTH STREET NORTHEAST RTVILLE, MN 55976						
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETE				
director of nursing administrative staff State agency and s want them to call m cell phone and star reach him, and he the administrator. I were submitted for submitted immedia agency and were m immediately to the he was aware the immediately and st problem." SUGGESTED CO administrator and o prohibition policies necessary, could e and procedures, ai vulnerable adult re reporting.	ly. n 6/11/15, at 9:34 a.m. the (DON) indicated the f were to submit reports to the stated, "Other staff can, but I ne." DON stated he carried a ff knew they could always would then report incidents to DON verified the reports that R64, R99, and R98, were not ately, as required, to the State not always reported administrator. DON indicated reports needed to be submitted stated, "We have a system	22000	DEFICIENCY)					
Vinnesota Department of Health								