DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VLKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245349**

2. STATE VENDOR OR MEDICAID NO. (L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/16/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 12/1/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/3/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245349

January 3, 2017

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 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 November 11, 2016 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds.

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 1, 2016

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

RE: Project Number S5349026

Dear Mr. Gustason:

On October 27, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 25, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 27, 2016, 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 November 25, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on August 25, 2016, and lack of verification of substantial compliance with the health deficiencies at the time of our October 27, 2016 notice. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, as of November 11, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 27, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 25, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 25, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 25, 2016, is to be rescinded.

In our letter of October 27, 2016, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 25, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245349 Y1	A. Building B. Wing Y2	11/16/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0246	Correction	ID Prefix F0315	Correction	ID Prefix F0329	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(l)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SPN	11/17/16	Marietta Lee, NFE-Nurse specialist #4	11-16-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/25/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245349 Y1	A. Building B. Wing Y2	11/16/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0246	Correction	ID Prefix F0315	Correction	ID Prefix F0329	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(l)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	12/01/2016	15425	11/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VLKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245349**

2. STATE VENDOR OR MEDICAID NO. (L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/20/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 11/9/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/30/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 27, 2016

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

RE: Project Number S5349026

Dear Mr. Gustason:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 20, 2016, the Minnesota Department of Health and on October 4, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 4, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on August 25, 2016.

However, compliance with the health deficiencies issued pursuant to the August 25, 2016 standard survey has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 25, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 25, 2016. They will also notify the State Medicaid Agency that they

must also deny payment for new Medicaid admissions effective November 25, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 25, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 February 25, 2017 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on October 18, 19, & 20, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 246} SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within reach for 3 of 50 residents (R58, R23, R59) reviewed in the facility for call light placement.	{F 246}	Stewartville Care Center assures that each resident receives care and services with reasonable accommodation of their individual needs and preferences.	11/11/16

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

Electronically Signed | 11/08/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 246}	Continued From page 1 Findings include: R58 was observed on 10/18/16 at 11:18 a.m., sitting in a lounge chair in resident room. There was no call light in sight or within reach. R58 stated did not know where the call light was or how to call staff for help. On further investigation the call light was located on the floor between the bed and bedside stand. R58 was observed on 10/18/16, at 2:15 p.m., sitting in lounge chair in resident room. Call light was located in same position on floor between the bed and the bedside stand. Document review of facility face sheet indicated R58 was admitted to facility on 2/19/16, with diagnosis that included right eye blindness. Document review of R58's care plan dated 10/16/16, indicated a history of falls with last fall on 2/18/16, which resulted in hospitalization (prior to facility admission). Care plan did not address approach of call light in reach. R23 was observed on 10/18/16, at 11:24 a.m., rested on own bed. There was no call light in sight or within reach. R23 stated had not needed to call staff for help. R23 indicated call light was at the foot of the bed. Call light was located at the foot of bed with cord in the bedside stand drawer and call light end of the cord hung outside of the drawer at the foot of the bed. R23 was observed on 10/18/16, at 2:15 p.m., walked from bathroom to resident bed and sat down on the bed. Call light was located in same location in bedside stand at foot of bed. Document review of R23's care plan dated	{F 246}	A comprehensive assessment is completed for each resident upon admission and with a significant change in condition. The goal is to provide services based on a plan of care that assists the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the greatest extent possible. The facility□s policy addressing call light availability was reviewed and found appropriate; resident□s are to have ready access to a call light when they are in their room. During mandatory meetings November 8 and 9, 2016, the staff will be reinstructed 1) on the facility policy for ensuring residents can alert staff to needs 2) that the residents□ ability to notify the staff of their needs must be maximized 3) that the call light or another communication device must always be left within reach of the residents when they are in their room and 4) that the care plan interventions addressing communication devices and options to alert the staff to residents□ needs must be followed. Staff from all departments were instructed to be observant for call light/device accessibility by the resident. The care plans for residents number 23, 58, and 59 were reviewed and updated as necessary to address call light accessibility. The direct care staff have been reminded that the call light should always be within reach of the residents when they are in the bed or chair.	

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{F 246}	Continued From page 2 10/11/16, directed problem of moderate fall risk, will ask for help if needs, last fall was 5/23/15. The approach included to place call light within easy reach and encourage R23 to use prior to transfer/walk, should R23 request any help. R59 was observed on 10/18/16, at 11:30 a.m., sitting in a wheelchair in R59's room playing cards on the over the bed table. There was no call light in sight or within reach. R59 verified no call light available and stated she would not be able to call staff. R59 located call light cord wrapped tightly around the bed grab bar next to the wall with the call light barely exposed. R59 indicated would have to go to the bed and reach across the bed mattress to reach the grab bar. R59 was observed on 10/18/16, at 2:15 p.m., not in resident room. Call light was observed in same location wrapped tightly around bed grab bar against the wall. Document review of R59's care plan dated 7/26/16, identified problem of mobility with no recent falls and minimal risk for falls. Care plan did not address call light in reach. During interview on 10/18/16, at 3:30 p.m., assistant director of nursing (ADON), verified R58, R23, and R59 were able to walk about the room and hallway by themselves and were able to independently use their call lights. During observations on 10/18/16, at 3:30 p.m., with ADON, R58's call light was attached to the recliner and R58 walked about R58's room independently with a walker. R58 stated the call light had been on room floor between the bed and bedside stand for "quite some time."	{F 246}	To monitor compliance, from November 4 to November 23, 2016 the Director of Nursing will assign staff to check call light accessability once daily for residents who are in their room. Call light accessibility will be audited during different times of the day. If noncompliance is noted additional auditing and staff training will be done. The residents□ satisfaction with accessability to call lights will be discussed during the November Resident Council Meeting and ongoing as necessary. Compliance will be reviewed during the December 2016 Quality Assessment and Assurance Committee meeting.	

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{F 246}	Continued From page 3 During observations on 10/18/16, at 3:30 p.m., with ADON, R23 sat on resident's bed eating a snack. Call light remained at the bed side stand at the foot of the bed. R23 stated had not used the call light. During observations on 10/18/16, at 3:30 p.m., with ADON, R59's call light remained wrapped tightly around the bed grab bar against the wall. When asked how R59 would use the call light, R59 stated "who knows." During interview on 10/18/16, at 3:30 p.m., ADON verified call lights for R58, R23, and R59 were not accessible and stated she expected call lights to be within resident reach. The facility policy Call Light, Use Of, dated 9/2016, indicated Procedure: H. When providing care to residents be sure to position the call light conveniently for the resident to use and within their reach. Tell the resident where the call light is and show him/her how to use the call light. K. Be sure all call lights are placed within reach of the resident.	{F 246}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	{F 315}		11/11/16

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{F 315}	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services to maintain bladder function to the highest extent as possible for 1 of 1 residents (R30) reviewed for urinary incontinence. Findings include: R30's quarterly Minimum Data Set (MDS) dated 8/30/16, indicated R30 was always incontinent of bladder and always incontinent of bowel, was not on a toileting program for bladder or bowel, required total assistance for toileting and had moderate cognitive impairment. During observation on 10/19/16, at 10:04 a.m. nursing assistant (NA)-B and NA-C entered R30's room. NA-G and NA-C were observed to provide perineal cares and check and change R30's soiled (visible urine and bowel movement) incontinent brief. NA-B and NA-C failed to offer R30 the use of a toilet, commode or bedpan. R30's Bladder Data Form, dated 8/3016, indicated resident is frequently incontinent of bladder, stress urinary incontinence: incontinence without sensation of urine loss. Summary and Program Placement Decision: scheduled toileting/habit training, change attends every two hours and as needed. However, R30's care plan, problem start date 9/12/16, indicated incontinent of bladder and bowel and wears incontinence pads and needs	{F 315}	Based on the resident□s comprehensive assessment, Stewartville Care Center ensures that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Residents who are incontinent of urine are identified, assessed, and provided appropriate treatment and services to manage incontinence and to maintain/ achieve as much urinary control as possible. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident□s clinical condition demonstrates that catheterization is necessary. When a resident is admitted with an indwelling catheter, attempts are made to discontinue use of the catheter whenever possible. The policies and procedures for assessing urinary/bowel function, incontinence, and catheter use were reviewed and revised to improve documentation consistency between the bladder assessments and the related plan of care. Bowel and bladder function is an important part of the resident□s comprehensive assessment and a successful urinary incontinent management plan is recognized as having a significant impact on the residents□	

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{F 315}	Continued From page 5 incontinence care done by staff. Has a history of urge incontinence. Administer medications for bowels as ordered. One staff to do incontinence care at least every 3 hours and as needed. The nursing assistant care sheet, undated, indicated Toilet: Hoyer with two, Transfer: Hoyer with two, yellow pad. On 10/19/16, at 11:36 a.m., NA-C confirmed R30 was not offered the toilet or bedpan. On 10/19/16, at 10:50 a.m., registered nurse (RN)-A verified the documented information on R30's last completed Bladder Data Form, dated 8/30/16. RN-A stated R30 should have been offered toileting according to the bladder form data as the form read scheduled toileting/habit training, change attends every two hours and as needed. RN-A confirmed R30's care plan was not updated according to what was documented on the Bladder Data Form. RN-A confirmed R30's care plan and Bladder Data Form had documented conflicting information regarding how often R30 was to be toileted as the Bladder Data Form read every two hours and the care plan read every three hours. On 10/20/16, at 11:22 a.m., the assistant director of nursing (ADON) confirmed R30's Bladder Data Form dated 8/30/16 and R30's care plan. The ADON confirmed the Bladder Data Form and care plan had documented conflicting information regarding the type of incontinence R30 had and how often R30 was to be toileted. The ADON stated she would expect staff to offer the toilet. The ADON stated she would expect R30's care plan to be updated according to the Bladder Data Form. The ADON stated if R30 was not	{F 315}	quality of life. During the November 8 and November 9, 2016, mandatory meetings, the staff responsible for assessing bowel and bladder function and developing the related plan of care will be further counseled on the importance of conducting comprehensive assessments and developing care plans that are consistent with the assessment. The following will be reinforced with the licensed staff: 1) the need to develop an individualized plan of care with interventions to promote continence/manage incontinence that is based on the bowel/bladder assessment 2) the importance of timely updates and modifications to the resident□s bladder/incontinent management plan of care and 3) monitoring care delivery to assure compliance with the plan of care while respecting resident preferences for toileting. The certified nursing assistants will be counseled that performance expectations include being aware of and following the resident□s individualized toileting plan. Resident number 30 □ The resident□s bladder function was reassessed by a registered nurse November 3, 2016. The resident has no awareness of the need to void. The resident□s care plan was updated to reflect routine checks for incontinence with perineal hygiene provided as necessary. The certified nursing assistant□s care worksheets were reviewed for accuracy.	

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{F 315}	Continued From page 6 appropriate for offering the toilet then on the Bladder Data Form under the Summary and Program Placement Decision: Not appropriate for toileting or retraining program should have been marked instead of scheduled toilet training and habit training.	{F 315}	To monitor compliance, the Assistant Director of Nursing/designee will review the bowel/bladder assessments, care plans and nursing assistant worksheets for residents on toileting programs (as identified on the MDS) monthly for 2 months to ensure consistency in approaches for toileting/managing incontinence. The resident□s bowel/bladder function and toileting needs will continue to be addressed during the quarterly interdisciplinary care conferences with modifications to the resident□s plan of care made as necessary. If noncompliance with the procedures for bowel/bladder assessments and care planning is identified, additional auditing and staff training will be done. Compliance will be reviewed during the December 2016 Quality Assessment and Assurance Committee meeting.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	{F 329}		11/11/16

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{F 329}	Continued From page 7 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure clear indications and adequate monitoring for the use of prescribed antianxiety, antidepressant and antipsychotic medications for 1 of 3 residents (R26) and failed to identify resident specific mood/behavior symptoms for depression and anxiety for 1 of 3 residents (R62) reviewed for unnecessary medications. Findings include: R26's current physician orders identified orders for the following: paroxetine (Paxil) (antidepressant) 10 mg (milligrams) daily, Seroquel (antipsychotic) 25 mg daily and lorazepam (Ativan) (antianxiety) 2 mg/ml (milliliter) 0.5 mg (0.25 ml) every four hours as needed for anxiety/dyspnea/restlessness and diagnoses of depression, dementia with behavioral disturbances, hallucinations, other symptoms and signs involving appearance and behavior assault behavior and agitation. R26's Behavior/Intervention Monthly Flow	{F 329}	Stewartville Care Center staff ensure that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and	

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{F 329}	Continued From page 8 Record, dated 10/16, identified behavior: 1. negative statements, verbal outbursts anger. 2. Hallucinations/delusions: physically swinging arms, closing fists as in wanting to hit. The record lacked to identify what behavior or specific symptoms were associated with the prescribed medications paroxetine, Seroquel and lorazepam to determine the effectiveness of the medications. R26's care plan dated 9/29/16 included behavioral symptoms Problem: behavior: can be resistant to cares and exhibits verbally and physically abusive behaviors towards staff while receiving cares. These behaviors are manifested by swearing at staff, calling staff names, and striking/kicking out at staff. Miriam exhibits behaviors that may be disruptive to others. Miriam yells out when assisted with cares related to impaired cognition, legal blindness, hallucinations, and delusions. Allow to have control over situations, if possible. Clearly explain what care will be provided and explain the purpose of care and procedures to facilitate understanding. Convey an attitude of acceptance towards. Inform when you enter the room and purpose of the visit. Maintain a calm environment and approach to R26. Provide orientation to surroundings as needed. Provide step-by-step instructions to facilitate understanding and participation in her care. Problem dated 10/06/16: psychotropic use for depression: has diagnosis of depression and receives Paxil, Ativan and Seroquel. Occasionally will become verbally abusive toward staff. Recently has become combative/aggressive physically. According to family, has had outbursts of anger her whole life. She may be at risk for further decline in mood and behavior. Resident has had hallucinations at times, but is usually redirectable. Resident has stated she sees chickens, and when she was two	{F 329}	more often as indicated. The goal of Stewartville Care Center staff is that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and 2) related target behaviors and mood symptoms will be identified and tracked for residents receiving psychotropic medications. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering attempts are in compliance with regulatory guidelines. The policies and procedures related to the medication administration were reviewed and revised. The policies have been updated to address identification of specific symptoms related to the use of psychotropic medications. The social workers will now develop the plans of care addressing psychotropic medications and identify/track the related target behaviors and mood symptoms. During the mandatory meetings November 8 and November 9, 2016, the licensed nursing staff will be instructed on	

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{F 329}	Continued From page 9 years old she was almost killed by the chickens and roosters. Resident thinks that is why she sees the chickens now and she cannot eat poultry. Administer medication as ordered, take soon after meal or snack. Behavior sheet to document every shift and notify physician/nurse practitioner with significant change or threatening behaviors. DISCUS (Drug-Induced Movement disorders) to be done every six months. Observe for side/adverse effects: confusion, muscle tremors, skin rash, blurred vision, drowsiness, dry mouth, headaches, nausea/vomiting, unusually slow or fast heartbeat, dizziness, unsteadiness or sweating. Problem dated 9/29/16: psychosocial well-being: reports some occasional low mood and difficulty sleeping, however reports overall feels her mood is doing well. Complete a depression scale at least quarterly or as indicated. Encourage her to continue strong ties with family/friends. Encourage her to express feelings related to past roles and life experiences. Monitor for signs and symptoms of depression. Report changes to physician/nurse practitioner. R26's care plan was reviewed and also had not identified which resident symptoms/mood/behavior is associated with the antianxiety, antidepressant or psychotropic medication. On 10/20/16, at 11:02 a.m., the assistant director of nursing (ADON) verified R26's record sheet and care plan failed to identify what behavior or specific symptoms were associated with the prescribed medications paroxetine, Seroquel and lorazepam for adequate monitoring. The ADON verified R26's record sheet and care plan failed to include specific symptoms for anxiety and interventions to implement, including non -pharmacological interventions related to anxiety. The ADON stated the facility had a Guidelines for	{F 329}	1) the changes in policies regarding care plan development and behavior/mood tracking for residents receiving psychotropic medications 2) the documentation procedures for addressing target behaviors and mood symptoms for residents receiving psychotropic medications and 3) the need to ensure the care plan appropriately addressed target behaviors/mood symptoms. The direct care staff will be reminded of the importance of being observant of behaviors and reporting target behaviors and mood symptoms to the charge nurse. Resident number 26 □ The resident was receiving hospice services and died at the facility October 24, 2016. The resident□s medication regimen was reviewed as part of the facility□s quality improvement program. Resident number 62 □ The resident was admitted June 19, 2015. During a depression screening interview, the resident indicated she had little interest or pleasure in doing things, felt down, depressed, hopeless and stated she felt bad about herself and had a poor appetite. She was started on an antidepressant July 7, 2015. The resident□s mood improved and the antidepressant dose was reduced March 1, 2016. The resident□s most current depression screen shows no symptoms of depressed mood. Discontinuing the antidepressant will be discussed with the physician/nurse practitioner. The care plan was reviewed and revised to include	

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{F 329}	Continued From page 10 Administration of PRN Anti-Anxiety Medication sheet that would identify the symptoms for anxiety and the director of nursing (DON) was the person who ensured the sheet was filled out. The ADON stated R26 had started on the medication on 10/14/16, but the DON was gone and the sheet had not been filled out for R26. When queried who would fill out the sheet when the DON was gone, the ADON replied the DON was the only person at this time who filled out the sheet. R62's current physician orders identified an order for sertraline (Zoloft an antidepressant) 25 mg daily and diagnoses of anxiety and depression. R62's care plan included: problem dated 9/09/16, Psychotropic Drug Use: has diagnosis of anxiety/depression and receives Zoloft. R62 is at risk for falls due to psychotropic medication use. Administer medication as ordered, take soon after meal or snack. DISCUS (Drug-Induced Movement disorders) to be done every six months. Observe for side/adverse effects such as confusion, muscle tremors, skin rash, blurred vision, drowsiness, dry mouth, headaches, nausea/vomiting, unusually slow or fast heartbeat, dizziness, unsteadiness or sweating. Problem dated 8/30/16: Psychosocial well-being: has strong identification with her past roles as a clerk and a mother. R62's family is a good support and visits often. Complete a depression scale at least quarterly or as indicated. Encourage her to continue strong ties with family/friends. Encourage her to express feelings related to past roles and life experiences. Monitor for signs and symptoms of depression and report changes to physician. On 10/20/16, at 11:13 a.m., the ADON verified	{F 329}	the mood symptoms justifying the start of an antidepressant medication. To monitor compliance, the social workers will audit the care plans of all residents receiving antianxiety and antidepressant medications to ensure that the target behaviors and mood symptoms are identified. During the consultant pharmacist□s monthly medication audits and the quarterly interdisciplinary care conferences, the residents□ medication regimen will continue to be reviewed to assure that the medications used to manage behavior and mood symptoms are appropriately addressed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the December 2016 Quality Assessment and Assurance Committee meeting.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 11 R62's care plan/record had not included specific mood symptoms for depression to determine if the antidepressant was affective or not. The ADON stated the care plan should have been revised to include the mood symptoms for depression. The facility policy Psychotropic Medications, undated, indicated a resident has the right to be free from the use of unnecessary medications. Unnecessary drugs are identified as drugs that are given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a diagnosis, or reason for the drug. Psychotropic drugs are classified as an unnecessary drug unless appropriate diagnosis is identified. Procedure: H. Behavior monitoring will be ongoing and reviewed and addressed by licensed staff when completing weekly charting. Charting should include the frequency and intensity of targeted behavior. The policy failed to address identifying specific symptoms related to the use of psychotropic medications.	{F 329}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	{F 441}		11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 12 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices to prevent the spread of infection during the provision of emptying a catheter drainage bag for 1 of 2 residents (R74) reviewed for urinary catheter use and for 1 of 1 residents (R30) reviewed for urinary incontinence. Findings include: R74 was observed on 10/19/16, at 1:16 p.m. to have a urinary catheter bag emptied by nursing assistant (NA)-A. NA-A donned glove's, cleansed	{F 441}	Stewartville Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment for the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

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{F 441}	Continued From page 13 the drainage spout of the catheter leg bag with an alcohol wipe, opened the spout and drained the urine from the bag into a urinal. NA-A closed the drainage spout, dropped the alcohol wipe (used to cleanse the spout prior to draining the bag) on the floor, picked up the alcohol wipe off the floor and disposed of the alcohol wipe in the garbage. NA-A emptied the urine from the urinal into the toilet, removed gloves, washed hands and exited R74's room. NA-A failed to cleanse the drainage spout with an alcohol wipe after draining urine from the bag. Nettina, Sandra M. (Ed.), (2014). Lippincott Manual of Nursing Practice, 10th Edition (p. 783). Wolters Kluwer/Lippincott Williams and Wilkins. Read, "Management of the Patient with an Indwelling (Self-Retaining) Catheter and Closed Drainage System, Procedure (continued) Nursing Action 3. Empty the bag at regular intervals, making sure that the drainage valve/spout is not contaminated. a. Wash hands; put on gloves. b. Disinfect spigot. Empty the bag in a separate collecting receptacle for each patient. Disinfect spigot again." On 10/19/16, at 1:20 p.m., NA-A confirmed she had not cleansed the spout of the bag after draining urine from the bag. NA-A stated I dropped the alcohol wipe on the floor. NA-A confirmed she had only one alcohol wipe and was going to use the same alcohol wipe (used to clean the drainage spout prior to opening the spout) to cleanse the spout after draining the urine from the bag. NA-A stated I thought I had two alcohol wipes. On 10/20/16, at 10:29 a.m., the assistant director	{F 441}	record of incidences of infections and tracks any alternative actions taken related to infection control and 4) requires staff to clean their hands after each direct resident contact for which hand cleansing is indicated by accepted professional practice. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections. Policies and procedures specific to emptying catheter bags and related glove use and hand washing have been reviewed and found appropriate. During the mandatory meetings November 8 and November 9, 2016, the correct infection control techniques related to emptying urine collection bags was demonstrated to the nursing staff. The direct care staff were also instructed on the proper hand washing/gloving procedure when providing perineal care. The plan to monitor compliance will be directed by the Assistant Director of Nursing. Licensed nurses will be assigned to directly observe the certified nursing assistants providing perineal cares with a focus on correct hand washing and gloving techniques. A licensed nurse will also observe the certified nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

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{F 441}	Continued From page 14 of nursing (ADON) stated she would expect staff to cleanse the drainage spout of the catheter leg bag before opening the spout to drain the urine and after the spout is closed. The ADON stated she would expect staff to use a different alcohol pad for cleansing the spout before opening and after closing the spout. The facility policy Empty Foley or Leg Catheter Bag, dated 9/16, indicated Procedure: D. Have graduate/urinal container and alcohol wipes ready. F. Before opening tube clamp, wipe tube with alcohol wipe. H. After draining, wipe tube with alcohol wipe and close clamp. R30 was observed to receive peri cares on 10/19/16, at 10:04 a.m., by NA-B. NA-B entered R30's room, NA-A donned clean gloves but had not washed hands with soap/water, pulled down R30's incontinent product (soiled with visible urine and bowel movement), cleansed R30's perineal and buttocks area. Wearing the stool/urine soiled gloves NA-B was observed to have opened the lower drawer of R30's night stand, picked up a clean incontinent product and disposable wipes from the drawer and put on R30 then removed soiled gloves. After removing soiled gloves NA-B had not washed hands with soap/water then finish dressing, transferred into a wheelchair, combed hair, brushed denture and then NA-B washed hands with soap and water. On 10/19/16, at 10:32 A.M., NA-B when queried regarding had not removed gloves and wash hands immediately after providing perineal cares and had touched other items with soiled gloves during providing peri cares, stated "hmm," I thought I removed gloves after cleaning resident.	{F 441}	assistants emptying a catheter bag with a focus on the technique of cleansing the drainage spout before and after emptying the collection bag. The plan is to retrain and observe all routinely scheduled nursing assistants on the above procedures within the next two weeks with on-call staff being retrained/observed as quickly as possible. If noncompliance with infection control procedures/techniques is noted, additional observations and staff education will be done. Random observations of infection control practices and techniques will be ongoing as part of the facility□s continuous quality improvement program. Compliance will be reviewed during the December 2016 Quality Assessment and Assurance Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 15 On 10/20/16, at 10:29 a.m. the ADON stated she expected staff to know when gloves are soiled and when to change and wash hands at appropriate times during cares. When providing peri cares she would expect staff to wash hands, don gloves and after providing peri cares they need to remove gloves and wash hands before doing anything else. The ADON stated the plan of correction addressing this same citation (exited 8/25/16) included staff had been educated regarding infection control in a meeting and monitoring would be done regarding perineal cares. The ADON stated the facility had not monitored perineal cares as directed in the plan of correction for F441. The facility policy Standard Precautions, dated 9/16, indicated Procedure: 1. Hand Washing a. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. b. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to the other residents or environments. 2. Gloves c. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments.	{F 441}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245349 Y1	A. Building B. Wing Y2	10/20/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0278	Correction	ID Prefix	F0280	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.20(g) - (j)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed
LSC		10/04/2016	LSC		10/04/2016	LSC		10/04/2016
ID Prefix	F0332	Correction	ID Prefix	F0334	Correction	ID Prefix	F0425	Correction
Reg. #	483.25(m)(1)	Completed	Reg. #	483.25(n)	Completed	Reg. #	483.60(a),(b)	Completed
LSC		10/04/2016	LSC		10/04/2016	LSC		10/04/2016
ID Prefix	F0431	Correction	ID Prefix	F0514	Correction	ID Prefix		Correction
Reg. #	483.60(b), (d), (e)	Completed	Reg. #	483.75(l)(1)	Completed	Reg. #		Completed
LSC		10/04/2016	LSC		10/04/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/25/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245349	A. Building 01 - MAIN BUILDING 01 B. Wing	10/4/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 08/25/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 08/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 10/27/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 10/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VLKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245349**

2. STATE VENDOR OR MEDICAID NO. (L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/25/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
04/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Jaeckels, HFE NE II 09/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/17/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

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

RE: Project Number S5349026

Dear Mr. Gustason:

On August 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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.

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
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 25, 2016 (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 February 25, 2017 (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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		10/4/16

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

Electronically Signed | 09/21/2016

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

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current revised nursing home Bill of Rights revised in March 2016 was used by the facility. This had the potential to affect all 53 residents residing in the facility. Findings include: During the initial tour, on 8/22/16, at 12:04 p.m., observation revealed the Bill of Rights posted in the facility was dated 7/07. On 8/22/16, at 4:59 p.m., the director of nursing observed the Bill of Rights posted in the facility and confirmed the Bill of Rights posted was dated 7/07.	F 156	The goal of Stewartville Care Center is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission and as appropriate during the resident□s stay. The facility displays the names, addresses, and telephone numbers of all pertinent State client advocacy groups, the bill of rights, Medicare/Medicaid information, and complaint procedures in a prominent location accessible to residents and staff. The social workers are aware of the requirement to provide the residents with a copy of the revised Bill of Rights. On	

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F 156	Continued From page 3 On 8/22/16, at 5:03 p.m., social worker (SW)-B and SW-A stated upon admission residents were given a copy of the Bill of Rights. SW-B and SW-A showed surveyor a copy of the Bill of Rights being provided to the residents upon admission and the copy was dated, 7/07. SW-A stated they had been informed by the administrator a couple of months ago there was a new Bill of Rights coming out soon. SW-A and SW-B asked surveyor where they would be able to obtain a copy of the revised Bill of Rights. The facility policy Resident Rights, undated, indicated each resident and/or significant other is informed during admission process of his/her rights as outlined in the Patient's Bill of Rights, Theft and Loss Program, and Property Rights, and Eligibility for Medicaid.	F 156	August 24, 2016, the updated Bill of Rights information was posted in the main lobby of the facility. Updated booklets describing the Bill of Rights (January 2016 revision) were distributed to residents admitted after March 1, 2016. Updated booklets will be distributed to residents admitted before March 1, 2016 during his/her next care conference. Obsolete Bill of Rights information has been removed from circulation and the content of the new admission folders now include the revised Bill of Rights. To monitor compliance, the records of residents admitted after March 1, 2016 will be audited by the social worker to verify that the residents have received a copy of the revised Bill of Rights. Compliance will be reviewed during the September 2016 Quality Assurance Committee meeting.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was	F 246	Stewartville Care Center assures that individual needs are accommodated and	10/4/16

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F 246	Continued From page 4 within reach for 1 of 53 residents (R19) during the initial tour of the facility. Findings include: R19 was observed during the initial tour of the facility, on 8/22/16, at 12:06 p.m., she was observed to be in her room sitting a wheelchair next to her bed, near the foot of the bed. R19's call light was located near the foot of the bed. R19 when asked by surveyor if she could reach her call light, attempted to reach for her call light. R19 was unable to extend her arm far enough to reach the call light located on top of her bed from her wheelchair. At 12:43 p.m., R19 was laid on her backside, in her bed. R19's call light was wrapped around a grab bar located on the top right side of R19's bed. The call light pad was placed on the outside of the grab bar. R19 when queried if she could reach her call light stated, "Not very good." R19 attempted to reach for her call light, but was unable to extend her arm far enough to reach the call light pad located on the backside of the grab bar. At 12:46 p.m., surveyor alerted nursing assistant (NA)-E that R19 was unable to reach her call light. NA-E entered R19's room and asked R19 if she could reach her call light. R19 stated, I can't reach it." R19 attempted to reach her call light for NA-E, but R19 was unable to do so. NA-E then repositioned R19 onto her right side laid in bed. R19 was unable to reach her call light after being repositioned onto her right side laid in bed. NA-E then moved R19's call light pad closer to R19 and R19 was able to reach the call and stated she was able to reach the call light. NA-E stated R19 used to her call light before at that location and I do not know why R19 cannot reach it. Finally NA-E put call light within reach for R19. R19's care plan, dated revised 7/18/16, indicated R19 was a fall risk with approach that included	F 246	that each resident receives services with reasonable accommodations of their needs and preferences. A comprehensive assessment is completed for each resident upon admission and with a significant change in condition which identifies resident preferences regarding meals, bathing, social interactions, and leisure pursuits. The goal is to provide services based on a plan of care that assists the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the greatest extent possible in accordance with the resident□s life long patterns and preferences. The policy for call light availability was reviewed and found appropriate. During mandatory meetings the nursing staff were reinstructed 1) on the facility policy for ensuring residents can alert staff to needs 2) that the residents□ ability to notify the staff of their needs must be maximized 3) that the call light or another communication device must always be left within reach of the resident and 4) that the care plan interventions addressing communication devices and options to alert the staff to resident needs must be followed. All staff were instructed to be observant for call light/device accessibility by the resident. The care plan for resident number eight was reviewed and the use of staff alert devices was found appropriate. The direct care staff have been reminded that the	

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F 246	Continued From page 5 place call light within easy reach and encourage her to use it. On 8/25/16, at 1:26 p.m., the assistant director of nursing (ADON)-G stated even if a resident was not able to use the call light the call light should be should be within reach. On 8/25/16, at 1:36 p.m., the director of nursing stated he expected call lights to be within reach. The facility policy Call Light, Use Of, undated, indicated Procedure: H. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. K. Be sure all call lights are placed within reach of the resident.	F 246	call light should always be within reach of the resident when she is in the bed or wheel chair. Random checks of call light accessability for two weeks will be coordinated by the Assistant Director of Nursing. If noncompliance is noted additional auditing and staff training will be done. The residents□ satisfaction with accessability to call lights will be discussed during the October Resident Council Meeting and ongoing as necessary. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		10/4/16

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F 278	Continued From page 6 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R30) reviewed for activities of daily living. Findings include: R30's diagnosis found on resident face sheet include, age-related osteoporosis without current pathological fracture and Glaucoma with vascular disorder. Annual Minimum Data Set (MDS) dated 5/31/16, identified R30 to have had a decline in eating, changing from supervision to extensive assistance. MDS also identified R30 having an improvement in toileting having gone from total dependence for toileting use to extensive assistance. R30's care plan dated 6/7/16, identifies R30 received a general diet with regular textures and thin liquids. Care plan identifies staff are to monitor for need of assistance with meals. Care plan dated 6/13/16 identifies R30 is incontinent of bladder and bowel and wears incontinence pads and needs incontinence care done by staff.	F 278	Stewartville Care Center staff routinely complete assessments that accurately reflect the residents status. Assessments are completed according to CMS guidelines as outlined in the User s Manual for the Resident Assessment Instrument. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals and signs to certify that the assessment is completed. Each individual who completes a portion of the assessment signs to certify the accuracy of that portion of the assessment. The staff completing the assessment 1) are qualified to assess relevant care areas 2) are knowledgeable about the resident s status and needs 3) appropriately document the resident s medical, functional and psychosocial problems and 4) identify the resident strengths to maintain or improve medical status, functional abilities, and	

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F 278	Continued From page 7 Interventions include for staff to perform incontinence care at least every three hours and as needed (PRN). Interview on 8/23/16, at 5:08 p.m. with nursing assistant (NA)-C, stated R30 is on a check and change program and is changed while in bed. NA-C stated R30 doesn't use the toilet and requires total assistance from staff for cares. Interview on 8/24/16, at 7:23 a.m. with NA-B stated R30 was on a check and change program for toileting. NA-B stated R30 is able to feed herself completely after initial set up of meal. Interview on 8/24/16, at 9:01 a.m. with MDS coordinator, stated nursing assistants chart on residents during the MDS assessment period on a "dart chart program" that covers many areas of the MDS including activities of daily living (ADL) and dining needs. MDS coordinator stated she then takes the information that the aides have documented and completes the MDS based on that document review. MDS coordinator stated that she doesn't do any observation of cares or dining during the assessment period. MDS coordinator stated she was unaware of the training aides received on how to properly document ADL/dining needs. MDS coordinator stated the program does not alert her if there was a change from the previous MDS that was completed and is unaware if changes are present. Interview on 8/24/16, at 1:44 p.m. with MDS coordinator stated nurses aren't overseeing the charting the aides are completing during the assessment period. MDS coordinator stated, "I don't do observations." MDS coordinator stated she couldn't say whether the information was being accurately documented by the aides in the charting program. Interview on 8/25/16, at 10:00 a.m. with the	F 278	psychosocial status. The policies and procedures for completing the minimum data set (MDS), including data gathering, were reviewed. During the MDS assessment reference period, a licensed nurse will document a progress note addressing resident self-performance and staff support required to complete the activities of daily (ADLs). During the mandatory educational meetings, the nurses will be informed of the need to write a progress note addressing the resident□s ADLs and the certified nursing assistants will be reeducated on the instructions for MDS coding of the resident□s ability to perform ADLs and the amount of staff support required. The DART charting program includes a tutorial for completing MDS Section G (Functional Status) which is available on demand for the nursing assistant reference. Instruction on coding MDS Section G will be included as part of the mandatory educational meetings. Resident number 30 □ A quarterly MDS assessment was completed with an Assessment Reference Date of August 30, 2016. Accuracy of the ADL data recorded on the DART chart program by the certified nursing assistants were verified through staff interview and record review. The care plan was reviewed and found appropriate. To monitor compliance, a staff RN will	

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F 278	Continued From page 8 director of nursing (DON) stated observations for ADLs and dining should be completed or overseen by a nurse. Facility policy titled, "Resident Assessment Instrument" undated, identifies, "The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity".	F 278	audit the annual MDS assessments completed during a 30-day period to ensure consistency in the ADL coding on the MDS, the nurses progress notes, and the ADL documentation completed by the certified nursing assessments. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		10/4/16

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F 280	Continued From page 9 by: Based on interview and document review the facility failed to revise the care plan to include non-pharmacological interventions for 1 of 5 residents (R62) reviewed for pain; failed to monitor sleep before and after the increase of sleep medication for 1 of 5 residents (R11); failed to ensure chronic anxiety behaviors included non-pharmacological interventions and medications used to manage anxiety for 1 out of 5 residents (R26) reviewed for unnecessary medications. Findings include: R62 HAD NON-PHARMACOLOGICAL INTERVENTIONS OF COLD/HEAT WHICH WERE NOT AFFECTIVE FOR PAIN RELIEF AND NO OTHER NON-PHARMACOLOGICAL PAIN INTERVENTIONS ATTEMPTED AS PART OF THE PAIN MANAGEMENT REGIMEN: R62's quarterly Minimum Data Set (MDS), dated 5/18/16, indicated R62 was cognitively intact, received scheduled and as needed (PRN) pain medications, had not received non-pharmacological interventions for pain, occasional pain, hard to sleep at night due to pain, pain interfered with day to day activity and pain rate score of four. R62's care plan, dated 8/19/16, indicated Problem: hip fracture pain, post side hip fracture 6/19/15. R62 is independent with bed mobility, transfers and walking with walker and will ask for assist if needed, has had frequent pain and states it affects her sleep and activity. R62 receives scheduled and PRN Tylenol and Lortabs at bedtime and PRN and usually refuses ice packs. R62 was dismissed from physical and	F 280	Stewartville Care Center staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representative are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. The care plan policies and procedures were reviewed and found appropriate. During mandatory meetings, the nursing staff will be 1) informed of the regulatory requirement that the residents' care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates 3) reminded of the importance of including care plan interventions to promote sleep for residents being treated for insomnia and 4) addressing nonpharmacological care plan interventions as part of the pain management regimen for residents with pain as well as nonpharmacological interventions to treat symptoms of anxiety	

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F 280	Continued From page 10 occupational therapies, wraps on legs during the day. Interventions include administer pain meds and treatments as ordered and monitor effectiveness. R62 can transfer from bed to chair to position walker and up ad lib. Will use her call light and ask for stand by assist at night. R62's care plan failed to include non-pharmacological interventions for pain. R62's physician orders, dated 7/20/16, identified orders for Tylenol (analgesic) 325 mg three times a day PRN for pain and Lortab (narcotic) 5-325 mg - one tablet for pain rate 1-4 out of 10 and two tablets for pain rate 5-10 out of 10 every eight hours PRN. Not to exceed 3000 mg Tylenol daily. R62's MAR, dated 8/16, 5/16 and 4/16, identified R62 received the PRN Tylenol and PRN Lortab medications as ordered. R62's pain assessment, dated 8/15/16, indicated pain last five days: yes, backache in a.m. only, takes pain meds scheduled, states no PRN's needed. Pain frequency occasionally. Pain has limited day to day activities. Pain intensity: numeric rating scale of seven. In the a.m. once up moving feels better, stiff and then loosens up once starts moving, heat and ice do not really help. On 8/24/16, at 12:50 p.m., the assistant director of nursing (ADON)-G stated she would expect non-pharmacological measures for pain be carried over to the care plan from interview. On 8/25/16, at 10:14 a.m., the director of nursing (DON) verified R62's care plan as above. On 8/25/16, at 10:53 a.m., the director of nursing,	F 280	and reduce the need for PRN (as needed) antianxiety medications. Resident number 65 – The resident's care plan was reviewed and updated to address nonpharmacological interventions as part of the pain management regimen. The resident's pain level as well as satisfaction with the current pain management plan will be reassessed at least quarterly and more often if the resident has uncontrolled pain. Resident number 11 - The resident's care plan was reviewed and updated to include interventions to address insomnia and promote sleep. The resident's sleep patterns will be monitored and changes to the care plan will be made as appropriate. Resident number 26 - The resident's care plan was reviewed and updated to include nonpharmacological interventions to attempt to decrease the resident's symptoms of anxiety and avoid the use of PRN antianxiety medications. To monitor compliance, care plan audits will be conducted for all residents: 1) receiving medications to treat insomnia to ensure that interventions to promote sleep are addressed; 2) receiving PRN medications to treat pain to ensure that nonpharmacological interventions are included in the pain management regimen; and 3) receiving PRN medications to treat symptoms of anxiety to ensure that nonpharmacological interventions to	

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F 280	Continued From page 11 in regards to non-pharmacological interventions being care planned for a resident having pain and being administered PRN pain medications for pain, stated that would be good practice. The facility policy Comprehensive Care Plan, dated 3/13, indicated resident care plans shall be utilized by all personnel involved in the care of the resident and reviewed weekly by a licensed nurse and revised as needed. The interdisciplinary team in participation with the resident, resident's family member or legal representative shall review and revise the plan at least quarterly. R11 LACKED INSOMNIA INTERVENTIONS EVEN THOUGH R11 RECEIVED A HYPNOTIC FOR SLEEP: R11's Resident Face Sheet indicated diagnoses to include; insomnia, borderline personality disorder, major depressive disorder, and an anxiety disorder. R11's current physician orders included melatonin three milligrams (natural sleep aide medication) at bedtime and trazodone 100 milligrams at bedtime for chronic insomnia/depression/anxiety (antidepressant medication used for sleep). R11's Primary Care note dated 5/3/16 reads; "Trazodone increased to 75 mg every night on 9/23/15 and increased to 10 mg nightly on 2/16/16." R11's care plan was reviewed and no insomnia interventions to promote sleep were developed. On 8/25/16 at 9:48 a.m. the assistant director of nursing (ADON) stated, "We do not have sleep monitoring. I know social services was going to	F 280	decrease anxiety symptoms and the use of antianxiety medications are included. For the next 60 days, care plan audits will also be completed for new admissions and for residents who have new orders for PRN medications to treat anxiety, insomnia, and pain to ensure that care plans address the medications and nonpharmacological interventions as appropriate. For the next 90 days, an audit form will be used during the quarterly care conferences to track whether the care plan accurately reflects use of PRN antianxiety medications and nonpharmacological interventions to attempt prior to administration, nonpharmacological interventions to relieve pain prior to administration of PRN analgesics, and use of sleep aids and interventions to promote sleep. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	

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F 280	Continued From page 12 start something with that." On 8/25/16 at 9:57 a.m. social services(SS)-A stated nursing would be monitoring sleep, not social services. On 8/25/16 at 10:28 a.m. the pharmacy consultant stated, "They definitely should be monitoring sleep, especially after we try to do a GDR [gradual dose reduction]." Facility policy, Sleep Disorders, undated, reads; "..Monitoring 1. The physician and staff will monitor the resident's progress in improving sleep, and adjust interventions accordingly." R26 LACKED CARE PLAN INTERVENTIONS ADDRESSING CHRONIC ANXIETY INCLUDING NON-PHARMACOLOGICAL INTERVENTIONS: R26's diagnosis found on the resident face sheet identifies Adjustment disorder with depressed mood, Major Depressive disorder, restlessness and agitation and Anxiety disorder. R26's has an order for Ativan with a start date of 9/17/15. Order indicates 0.5 mg to 1 mg every eight hours as needed (PRN) for anxiety/agitation. Order does not indicate what R26's target behaviors. Review or PRN medication administration records from March 2016 through August 24, 2016, indicates R26 received oral Ativan on 32 occasions. Ativan gel from March 2016 to discontinue date of 8/23/16, was administered on six occasions. R26's care plan dated 6/22/16 identifies R26 can be resistant to cares and exhibits verbally and physically abusive behaviors towards staff while receiving cares. These behaviors are manifested by swearing at staff, calling staff names, and striking/kicking out at staff. R26 yells out when	F 280		

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F 280	Continued From page 13 assisted with cares related to impaired cognition, legal blindness, hallucinations and delusions. Care plan identifies R26 has short and long term memory problems. BIMS score was 5/15, indicating severe impairment. R26 is usually able to participate in 1:1 conversation and is usually understood and able to make her needs known. Care plan addresses R26's Psychotropic use for Depression. However, there is no interventions for chronic anxiety or symptoms associated with anxiety nor non-pharmacological interventions to use before use of antianxiety medication. Interview on 8/25/16, at 10:29 a.m. with registered nurse, (RN)-B stated a problem related to anxiety and the use of Ativan should have been included on the care plan. RN-B stated when a medication is started, it should be added to the care plan by whatever nurse is entering the new medication. RN-B stated care plans are reviewed at every care conference and updates when necessary. Interview on 8/25/16, at 10:52 a.m. with director of nursing (DON) stated care plans are reviewed prior to care conferences and staff should be reviewing care plans in between those times and updating as needed. DON stated R26's care plan should have included Anxiety diagnosis with symptoms as well as the use of Ativan. Policy titled, "Comprehensive Care Plan" dated 3/2013, identifies, "This is a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals which include: the physician ' s orders for medication, treatments, types of care and consultation services needed". Resident care plans shall be reviewed weekly by a licensed nursed and revised as needed. The interdisciplinary team shall review and revise the plan at least quarterly.	F 280		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain bladder function to the highest extent as possible for 1 of 2 residents (R2) reviewed for urinary incontinence and failed to provide medical justification for use of an indwelling catheter after admission to the facility or ongoing reassessment for continued need for 1 of 2 residents (R57) reviewed for ongoing urinary catheter use. Findings include: R2 LACKED A TOILETING SCHEDULE BASED ON THE COMPREHENSIVE BLADDER ASSESSMENT AND VOIDING RECORD ALSO OFFERING TOILETING AS CARE PLANNED: R2's significant change in status annual Minimum Data Set (MDS) dated 5/23/16, indicated R2 was frequently incontinent of bladder, was always incontinent of bowel, was not on a toileting program for bladder or bowel, required total assistance to transfer and toilet and was	F 315	Based on the resident□s comprehensive assessment, Stewartville Care Center ensures that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The facility ensures that each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident□s clinical condition demonstrates that catheterization is necessary. When a resident is admitted with an indwelling catheter, attempts are made to discontinue use of the catheter whenever possible.	10/4/16

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F 315	Continued From page 15 cognitively intact. On 8/22/16, at 6:43 p.m., R2 stated she was unable to use the toilet in the bathroom as staff were unable to get her into the bathroom due to having to use the Hoyer to transfer her. R2 stated staff do not put her on the toilet in her room, "I just go in my pants, and I am not happy about that, would you be?" R2 stated the staff had a commode in here but it did not work very well so they stopped using the commode. They offered the bed pan, but I do not like bed pans. R2 stated, when queried if therapy had worked with her on assisting to get on and off the toilet/commode using the Hoyer lift she stated, "No." During continuous observation, on 8/23/16, from 2:47 p.m., until 4:28 p.m., R2 laid in bed sleeping. At 4:28 p.m., nursing assistant (NA)-G and NA-F entered R2's room. NA-G and NA-F were observed to provide perineal cares and check and change R2's soiled (visible urine and bowel movement) incontinent brief. NA-G and NA-F failed to offer R2 use of a toilet or commode. R2's Bowel and Bladder Assessment, dated 5/23/16, completed by registered nurse (RN)-C, indicated voiding pattern: per bowel and bladder screen tool: every one to four hours, impaired mobility, condition is terminal on Hospice. Type and frequency of Assistance: assist to toilet/commode, assist of two, and use of mechanical lift. Type of urinary incontinence: stress "?" and functional. Interventions: scheduled toilet program and check and change toilet program. Use of incontinent product: yellow brief. Comment: frequently incontinent bladder and bowel, history of urinary tract infections (UTI).	F 315	The policies and procedures for assessing urinary/bowel function, incontinence, and catheter use were reviewed and found appropriate. Bowel and bladder function is considered an important part of the resident□s comprehensive assessment and is recognized as having a significant impact on the residents□ quality of life. During the mandatory educational meetings, the staff responsible for assessing bowel and bladder function and developing the related plans for care will be further counseled on the importance of following facility policies for conducting comprehensive assessments and developing appropriate care plans. The following will be reinforced with the licensed staff: 1) the need to develop an individualized plan of care with interventions to promote continence/manage incontinence 2) the importance of timely updates and modifications to the resident□s bladder/incontinent management plan of care 3) ensuring that residents who are catheterized have referrals/consults/diagnosis to justify the use of a catheter and 4) monitoring care delivery to assure compliance with the plan of care while respecting resident preferences for toileting. The certified nursing assistants will be counseled that the management expectation includes being aware of and following the resident□s individualized plan of care for toileting.	

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F 315	Continued From page 16 R2's care plan, problem start date 5/31/16, indicated the resident has been incontinent of bladder and bowel, wears attends and needs extensive assist for toileting from staff. Hospice will bring in commode for use of bowel movements. Interventions included administer medications as ordered by physician for bowels, monitor and report signs and symptoms of UTI, record bowel movements daily, two staff to assist to transfer to and from with Hoyer (mechanical lift), remind and assist her to adjust clothing and do perineal care at her request. The nursing assistant care sheet, undated, indicated Toilet: request. Transfer: Hoyer, two assist, yellow pad and fall mat by bed. On 8/23/16, at 4:44 p.m., NA-G when queried how staff know when R2 needs toileting, stated we check R2 at the most every two hours. NA-G stated she only works part-time right now and she had never heard R2 ask to be toileted. NA-G verified the nursing assistant care sheet read toilet: request. On 8/23/16, at 4:58 p.m., NA-F when queried how staff know when R2 needs toileting, stated there was nothing standard or specific periods. NA-F stated on the night shift we toilet every two hours and during the day I toilet residents when I first come on shift, then again when preparing to go to supper and the when residents get ready to go to bed, so three times during the day shift I would toilet R2. NA-F, when queried regarding if R2 requested toileting or put on the call light to be toileted, stated I have not had that experience with R2, R2 has not called, not even once, not even when R2 has a bowel movement, but when	F 315	Resident number 2 □ The resident was receiving hospice services with care plan goals to maximize comfort and dignity with toileting needs. The resident died at the facility on September 7, 2016. The record of care was reviewed as part of the facility□s ongoing quality improvement process. Resident number 57 □ When contacted on August 27, 2016, the nurse practitioner verified that the resident had a Foley catheter due to urinary retention secondary to a cerebral vascular accident. The resident is not a candidate for intermittent catheterization due to pain with catheterization. The resident will be seen by the nurse practitioner on September 13, 2016, for further examination. A urology consult will be recommended to the resident. Compliance will be monitored by the Assistant Director of Nursing/designee through review of the bladder/bowel assessments and the elimination plans of care for residents admitted during 60-day period starting August 1, 2016. Resident preferences, toileting schedules, and staff assistance will be reviewed during the record audits. If noncompliance is noted, additional auditing and staff training will be done. The resident□s bowel and bladder function and toileting needs will continue to be addressed during the quarterly interdisciplinary care conferences. Modifications to the resident□s plan of care will be made as necessary. Compliance will be reviewed during the	

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F 315	Continued From page 17 you work with R2 and you ask R2 she will respond. On 8/25/16, at 8:55 a.m., RN-B stated R2 was incontinent of bowel and bladder and when R2 returned to the facility the staff had tried to get R2 up on the toilet. RN-B stated R2 was not able to feel when she had to go and was not able to give enough warning when she had to get up onto the toilet. RN-B stated, "Boy did that backfire." RN-B stated she did not think R2 was aware now when she needs to go, so the goal would be to prevent skin breakdown. RN-B stated we can offer the toilet to R2, but she did not know what kind of response R2 would give or if R2 was able. On 8/25/16, at 9:05 a.m., RN-C stated Staff were to check and change R2 as R2 was on Hospice. RN-C verified R2's care plan and nursing assistant care sheet as above. RN-C stated according to R2's assessment, dated 5/23/16, R2's normal voiding pattern was every one to four hours. RN-C stated R2 was using the commode when R2 started on Hospice and after she came back from the hospital her incontinence changed for both bowel movements and voiding, as well as check and change. RN-C stated R2 was frequently incontinent of bowel and bladder and Hospice was bringing in a commode for R2 to use, so R2 would be assist of two using a lift to transfer onto the commode. RN-C stated staff should be doing every hour toileting with R2 if trying to decrease R2's incontinence, as R2's voiding pattern as every one to four hours. RN-C stated she would expect staff to offer the toilet to R2 when staff were checking and changing R2. RN-C confirmed R2's care plan and nursing assistant care sheet lacked indication of how often R2 was to be toileted, and to offer	F 315	September and December 2016 Quality Assessment and Assurance Committee meetings.	

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F 315	Continued From page 18	F 315		

bedpan/commode/toilet and/or check and change. RN-C stated she does not usually complete the bowel and bladder assessments, but the person was gone at the time R2's assessment was due. RN-C stated it was a joint thing in regards to updating the care plan. RN-C stated she does not revise the care plan, the floor nurses revise and update the care plans. RN-C stated she updates the care plan as well if she notices something she will put it on the care plan.

On 8/25/16, at 10:31 a.m., the director of nursing (DON) verified R2's care plan and nursing assistant care sheet as above. The DON stated R2's care plan and nursing assistant care sheet should have been updated when the most current (MDS dated 5/31/16) was done. The DON stated he would expect staff to offer the toilet to R2 when staff were changing R2. The DON stated he thought R2 used to be able to ask for the toilet and would tell staff, but since R2 medically changed that has not been the case. The DON stated if the assessment indicated should offer toilet, staff should offer the toilet. The DON stated he thought a voiding pattern of one to four hours seemed really broad and staff should be asking R2 and changing R2 every one to two hours.

The facility policy Urinary Continence and Incontinence Assessment and Management, undated, indicated Purpose: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.

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F 315	Continued From page 19 R57 HAD BEEN ADMITTED TO FACILITY WITH AN INDWELLING CATHETER IN 2014. HOWEVER, MEDICAL NEED FOR INDWELLING CATHETER HAD NOT BEEN DETERMINED AFTER ADMISSION BUT A COMPREHENSIVE BLADDER ASSESSMENT WAS NOT COMPLETED OR ONGOING REASSESSMENT TO DETERMINE CONTINUED NEED FOR THE CATHETER USE AND THE DEVELOPMENT OF A PLAN FOR REMOVAL OF THE INDWELLING CATHETER: During stage one of the survey process, interview with registered nurse (RN)-B, on 8/22/16, at 2:41 p.m. identified R57 had a diagnosis of benign prostatic hyperplasia (BPH), which is the enlargement of the prostate gland. Review of R57's diagnosis found on the Diagnosis Report identifies R57 to have a diagnosis of "other specified disorders of bladder-BLADDER SPASMS." Diagnosis report did not identify a diagnosis of BPH. R57 was admitted to the facility on 11/4/14. R57 was admitted from St. Mary's Hospital with an indwelling Foley catheter. Dismissal summary dated 11/4/14, from St. Mary's Hospital identifies R57 was in the hospital related to having a stroke. Dismissal summary identifies the urinary catheter was placed on 11/2/14. Dismissal summary identifies urinary management for the indwelling catheter indication was a "failed in and out catheter trial." Summary identifies, "able to switch to in and out cauterization if amenable, was too painful before." Admission progress note completed by nursing dated 11/4/14, at 11:15 a.m. identifies R57 has an "indwelling Foley, blood tinged urine. Reported had high residual in the hospital, painful I&O caths. For comfort, indwelling Foley. POA (power of attorney) agrees to keep Foley in until he	F 315		

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F 315	Continued From page 20	F 315		

advances with therapy." According to the Minimum Data Set (MDS) R57 had not received any form of occupational therapy or physical therapy until a year following admission to the facility.
Annual Minimum Data Set (MDS) dated 2/2/16 for bladder uses indwelling catheter, BIMS 11 of 15 cognitively intact. Needs extensive assist with activities of daily living (ADLs).
Quarterly Minimum Data Set (MDS) dated 8/2/16, identifies R57 to have a BIMS score (brief interview of mental status) of 14/15 which indicates R57 is cognitively intact. MDS identifies R57 requires extensive assist of one to two staff for activities of daily living (ADL) assistance. MDS identifies a urinary toileting program (includes scheduled toileting, prompted voiding or bladder training) has not been attempted. MDS identifies R57 attended occupational therapy (OT) from 11/5/15 to 2/24/16 and physical therapy (PT) from 3/24/16 to 4/29/16. Also has an indwelling catheter.
Bowel and Bladder Assessment Summary completed on 2/8/16 by the MDS coordinator RN identifies R57 is at risk of catheter blockage, pain causing urine to bypass catheter, breakage of catheter bulb, bleeding. Bowel and Bladder Assessment Summary does not identify where information was obtained.
Bladder Data Form dated 8/2/16, identifies R57 the contributing diagnosis or medical condition for the Foley catheter is related to R57 having had a stroke. Bladder Data Form was completed by an RN and a licensed practical nurse (LPN).
On asking for information of R57 having had a consultation with the urologist to determine if less intrusive measures had been recommended by the urologist. None was provided by the facility.
Current physician orders with start date of 11/4/14

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F 315	Continued From page 21 include Belladonna-Opium Suppository 16.2-30 mg; administer one suppository rectally every six hours as needed (PRN) and to change Foley catheter the 1st of every month. Review of PRN medication administration record identified R57 received medicated suppository on six different occasions since March 2016 until present date with progress notes identifying reason for giving as bladder spasms. Interview on 8/24/16, at 8:05 a.m. with LPN-C stated R57 had a catheter due to having a stroke. LPN-C checked the computer for the diagnosis associated with the catheter and stated the only diagnosis was bladder spasms. LPN-C stated R57 has a lot of bladder spasms with the monthly catheter changes and requires a medicated suppository before the catheter is changed to decrease the discomfort associated with the bladder spasms. LPN-C stated R57 has bladder spasms at other times as well that require the medicated suppository. Interview on 8/24/16, at 8:36 a.m. with the assistant director of nursing (ADON) stated there should have been a diagnosis for the use of the catheter when R57 was admitted to the facility. ADON stated when a resident enters the facility with a catheter the facility process is to attempt to remove the catheter. ADON stated there should have been documentation from the facility and from the medical provider supporting the continued use of the catheter or documentation related to attempts to discontinue the catheter use. Interview on 8/24/16, at 9:42 a.m., with R57 when asked about catheter stated, "I hate the [curse word]." R57 stated he thought the catheter was placed due to excessive fluid. R57 denied having any difficulty with urinating prior to the catheter being placed. R57 stated the facility had never	F 315		

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F 315	Continued From page 22 tried to remove the catheter. R57 stated he hadn't asked for the catheter to be removed and stated, "I figure they know what they are doing." R57 stated, "I sure have suffered with it, I don't think I can take it off, I think my body depends on it, I'd like to take it off and be done with it." Interview on 8/25/16, at 9:39 a.m. with director of nursing (DON), stated if R57 had been seen by urology at all during his time in the facility the progress notes would be found in Matrix (computerized charting system facility uses to document care). DON was unable to find a diagnosis for the use of the Foley catheter. DON stated when a resident enters the facility with a catheter it is usually for a short time period and there are usually specific instructions from the medical provider related to how long the catheter should stay in place, if I&O (intake and output) should be completed but for R57 there isn't anything. DON stated the catheter could be contributing to R57's bladder spasms. Facility policy titled, "Resident with an indwelling Catheter", undated, identified, "the comprehensive assessment should include underlying factors supporting the medical justification for the initiation and continuing need for catheter use". "Appropriate indications for continuing use of an indwelling catheter beyond 14 days may include: urinary retention that cannot be treated or corrected medically or surgically, documented post void residual volumes in a range over 200 milliliters, inability to mange the retention/incontinence with intermittent cauterization, persistent overflow incontinence, symptomatic infections and/or renal dysfunction".	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		10/4/16

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F 329	Continued From page 23 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify specific mood/behavior symptoms for depression and anxiety and failed to consistently document if non-pharmacological interventions were effective for use of as needed (PRN) pain medications for 1 of 5 residents (R62) reviewed for unnecessary medications; failed to monitor sleep to evaluate the need for sleep medication for 1 of 5 residents (R11); failed to ensure clear indications, defined parameters, and adequate monitoring for the use of the antianxiety	F 329	Stewartville Care Center staff ensure that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose	

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F 329	Continued From page 24 medications for 1 of 5 residents (R26) who had chronic anxiety/behavior symptoms/signs. Findings include: R62 LACKED RESIDENT SPECIFIC TARGET BEHAVIORS/MOOD TO DETERMINE IF ANTIDEPRESSANT WAS AFFECTIVE AND IF ANTIANXIETY MEDICATION WAS AFFECTIVE: R62's quarterly Minimum Data Set (MDS), dated 5/18/16, indicated R62 was cognitively intact, feeling tired or have little energy, no behaviors, diagnoses of anxiety and depression, received scheduled and as needed (PRN) pain medications. R62's care plan, dated 8/19/16, indicated Problem: R62 has diagnosis of anxiety/depression and receives Zoloft. R62 is at risk for falls due to psychotropic med use. Interventions included administer medication as ordered, take soon after meal or snack, DISCUS to be done every six months, observe for side/adverse effects such as confusion, muscle tremors, skin rash, blurred vision, drowsiness, dry mouth, headaches, nausea/vomiting, unusually slow or fast heartbeat, dizziness, unsteadiness or sweating. Also Problem: psychosocial well-being. R62 has strong identification with her past roles as a clerk and a mother. Interventions included complete a depression scale at least quarterly or as indicated, DISCUS every 6 months, encourage her to continue strong ties with family/friends, encourage her to express feelings related to past roles and life experiences, monitor for signs and symptoms of depression and report changes to physician. Started on Zoloft 7/7/15. R62's physician orders, dated 7/20/16, identified	F 329	should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and more often as indicated. Stewartville Care Center staff ensures that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record 2) nonpharmacological interventions will be attempted prior to administration of PRN (as needed) psychotropic medications and analgesics 3) target behaviors will be identified for residents receiving selected psychotropic medications and 4) sleep assessments will be completed and sleep/wake patterns will be monitored for residents receiving medications to treat insomnia. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering	

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F 329	Continued From page 25 an order for Zoloft (antidepressant) 25 mg (milligrams) once a day. R62's medication administration record (MAR), dated 8/16 revealed R62 was receiving the medication as ordered. R62's facility quarterly review for Zoloft, dated 8/19/16, indicated anxiety: improve willingness to participate in therapies. Gradual dose reduction 3/25/16, non-pharmacological interventions activities, social service, pharmacy review drug, physician update. R62's Behavior Intervention Monthly Flow Records dated 4/2016 through 8/16, identified Anxiety: improve willingness to participate in therapies with no documented episodes of behavior. However, R62's care plan for problem of pain, indicated R62 was dismissed from physical and occupational therapies. LACK OF NONPHARMACOLOGICAL INTERVENTIONS FOR PAIN: R62's care plan, dated 8/19/16, indicated Problem: hip fracture pain, post side hip fracture 6/19/15. R62 is independent with bed mobility, transfers and walking with walker and will ask for assist if needed, has had frequent pain and states it affects her sleep and activity. R62 receives scheduled and PRN Tylenol and Lortabs at bedtime and PRN and usually refuses ice packs. R62 was dismissed from physical and occupational therapies, wraps on legs during the day. Interventions include administer pain meds and treatments as ordered and monitor effectiveness. R62 can transfer from bed to chair to position walker and up ad lib. Will use her call light and ask for stand by assist at night.	F 329	attempts are in compliance with regulatory guidelines. The policies and procedures related to the medication administration were reviewed and revised. The policies will address the documentation of nonpharmacological interventions. During the mandatory educational meetings, the licensed nursing staff will be instructed on 1) the documentation procedures for target behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration of PRN psychotropics and analgesics and documenting the result/effectiveness of the interventions 3) ensuring the care plan addresses target behaviors and nonpharmacological interventions to manage mood symptoms, anxiety and pain 4) and the need for an assessment that analyzes the sleep monitoring data. The direct care staff will be reminded of the importance of being observant of behaviors and reporting target behaviors to the charge nurse. Resident number 62 □ The resident□s mood was assessed by the social worker September 13, 2016. According to the social service note, the resident has adjusted well to the long term care setting and has no current symptoms of anxiety (diagnoses reflect history of anxiety); the resident does not receive antianxiety medication. The behavior monitoring log tracking symptoms of anxiety will be discontinued. The resident receives Zoloft	

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F 329	Continued From page 26 R62's physician orders, dated 7/20/16, identified orders for Tylenol (analgesic) 325 mg three times a day PRN for pain and Lortab (narcotic) 5-325 mg - one tablet for pain rate 1-4 out of 10 and two tablets for pain rate 5-10 out of 10 every eight hours PRN. Not to exceed 3000 mg Tylenol daily. R62' s medication administration record (MAR), dated 8/16, 5/16 and 4/16, identified R62 received PRN Tylenol and PRN Lortab medication. The MAR's failed to include consistently documented non-pharmacological interventions prior to administration of the medication, reasons for use and the result/outcome of use for the PRN pain medications. R62's pain assessment, dated 8/15/16, indicated pain last five days: yes, backache in a.m. only, takes pain meds scheduled, states no PRN's needed. Pain frequency occasionally. Pain has limited day to day activities. Pain intensity: numeric rating scale of seven. In the am once up moving feels better, stiff and then loosens up once starts moving, heat and ice do not really help. On 8/24/16, at 12:50 p.m., the assistant director of nursing (ADON) stated she would expect the reason for use and effectiveness of the PRN pain medication be documented. The ADON stated she would expect non-pharmacological interventions to be tried before administration of the PRN pain medication. On 8/25/16, at 8:15 a.m. the consultant pharmacist (CP)-C stated she would expect specific symptoms for depression and anxiety to be identified for the use of Zoloft. Also stated in regards to non-pharmacological interventions	F 329	for treatment of depression; the most recent gradual dose reduction was March 1, 2016. The resident does experiences insomnia which could be related to the depression. The interdisciplinary team will continue to review the resident□s mood and the effectiveness of her pain management program. The care plan has been reviewed and revised to include symptoms of depression and the need to document nonpharmacological interventions to relieve pain, reasons for use of PRN (as needed) analgesics, and the result/outcome of PRN analgesic administration. Resident number 11 □ The resident□s sleep/wake patterns will be tracked for two days. After that time a nurse will assess the data to determine the effectiveness of the medications prescribed for insomnia. The nurses will routinely document on the resident□s sleep patterns. Resident number 26 □ The resident□s care plan has been revised to include symptoms associated with anxiety, the use of Ativan to assist with anxiety symptoms, interventions to decrease symptoms of anxiety, and nonpharmacological interventions to attempt before administering PRN (as needed) medication to manage anxiety. The Ativan order has been changed to 0.5 mg every 8 hours PRN; may repeat in one hour if not effective. During the consultant pharmacist□s	

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F 329	Continued From page 27 tried before administration of a PRN pain medication and reasons for use and effectiveness of the PRN pain medication to be documented every time the medication was given. On 8/25/16, at 10:14 a.m., the director of nursing (DON) in regards to documenting specific symptoms identified for depression and anxiety, the DON stated a good practice would be to document symptoms that you notice with that individual for depression and anxiety. The DON stated R62's behavior/intervention monthly flow record sheet should identify specific symptoms as well as behavior. The DON stated non-pharmacological interventions should be tried first before giving a PRN pain medication, follow up of whether the pain was better or worse after administration of the medication and the reason the medication was administered should be documented. The facility policy Psychotropic Medications, undated, indicated E. Behavior monitoring will be initiated when psychotropic drug usage is identified per facility policy. H. Behavior monitoring will be ongoing and reviewed and addressed by licensed staff when completing weekly charting. Charting should include the frequency and intensity of targeted behavior. R11 RECEIVED HYPNOTIC HOWEVER, A COMPREHENSIVE SLEEP ASSESSMENT HAD NOT BEEN COMPLETED OR NONPHARMACOLOGICAL INTERVENTIONS: R11's Resident Face Sheet indicated diagnoses to include; insomnia, borderline personality disorder, major depressive disorder, and an anxiety disorder.	F 329	monthly medication audits and the quarterly care planning process, the residents medication regimen will continue to be reviewed to assure that the medications used to manage behaviors, mood symptoms, insomnia and pain are appropriately justified and monitored. Compliance will be further monitored by the Director of Nurses/designee by 1) an audit of the records of residents receiving antianxiety and antidepressant medications to ensure that the target behaviors/mood symptoms are identified, monitored, and related interventions are documented 2) an audit of the records of residents receiving PRN pain medications to ensure that nonpharmacological interventions and monitoring of their effectiveness are included the plan of care and appropriately documented and 3) a record audit of residents receiving medication to treat insomnia to ensure sleep assessments have been completed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	

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F 329	Continued From page 28 R11's current physician orders included melatonin three milligrams (natural sleep aide medication) at bedtime and trazodone 100 milligrams at bedtime for chronic insomnia/depression/anxiety (antidepressant medication with hypnotic effects). Trazodone increased on 9/23/15 and again on 2/16/16 to current dose. R11's care plan lacked interventions for insomnia. On 8/25/16 at 9:48 a.m. the assistant director of nursing (ADON) stated, "We do not have sleep monitoring. I know social services was going to start something with that." On 8/25/16 at 9:57 a.m. social services(SS)-A stated nursing would be monitoring sleep, not social services. On 8/25/16 at 9:50 a.m. licensed practical nurse-D stated regarding sleep monitoring; "I remember hearing that for a while we were on nights in a progress note because she would report being up all night." On 8/25/16 at 10:28 a.m. the pharmacy consultant stated, "They definitely should be monitoring sleep, especially after we try to do a GDR [gradual dose reduction]." Facility policy, Sleep Disorders, undated, reads; "..Monitoring 1. The physician and staff will monitor the resident's progress in improving sleep, and adjust interventions accordingly." R26 LACKED SPECIFIC RESIDENT MOOD/BEHAVIOR TO TRACK TO DETERMINE IF ANTIANXIETY AND ANTIDEPRESSANT MEDICATION HAD BEEN AFFECTIVE NOR WAS CLEAR PARAMETERS GIVEN AS TO	F 329		

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F 329	Continued From page 29 WHEN RANGE OF ATIVAN WAS TO BE USED: R26's diagnosis listed on the resident face sheet identified adjustment disorder with depressed mood, major depressive disorder, restlessness, agitation and anxiety disorder. R26's had an order for Ativan with a start date of 9/17/15, and read 0.5 milligrams (mg) to 1 mg every eight hours as needed (PRN) for anxiety/agitation. The physician order did not outline what R26's targeted behaviors were. The order lacked guidance, for nursing staff, as to when 0.5 mg versus 1 mg was to be administered. From 3/2016 to 8/2016 R26 received Ativan tablet or gel for a combined 38 times. The Ativan 0.5 mg tablet or gel was administered on 12 occasions, the remaining 26 times the Ativan 1 mg was administered. Also on 28 occasions identified agitation, anxiety or yelling was reason for administration without specific symptoms of anxiety or agitation. 24 times there was a documented follow up of effectiveness to medication. Review of medication administration records from March 2016 through August 24, 2016, indicated R26 received oral Ativan on 32 occasions. Ativan gel from March to discontinue date of 8/23/16, was administered on six occasions. R26's behavior monitoring sheets identified target behaviors to include negative statements, outburst of anger, hitting, kicking, verbally abusive. Target behavior monitoring sheets reviewed from March 2016 through August 24, 2016 with 21 documented behaviors or interventions. Behavior sheets have the same target behaviors for depression, adjustment disorder, agitation and anxiety, without indication of what behaviors to monitor for what diagnosis.	F 329		

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F 329	Continued From page 30 R26's care plan dated 6/22/16, identified R26 could be resistant to cares and exhibited verbal and physically abusive behaviors towards staff while receiving cares. These behaviors were manifested by swearing at staff, calling staff names, and striking/kicking out at staff. R26 yelled out when assisted with cares related to impaired cognition, legal blindness, hallucinations and delusions. Care plan identified R26 had short and long term memory problems. The care plan did not address R26's anxiety or symptoms associated with anxiety or the use of Ativan to assist with anxiety symptoms. It did not include interventions to decrease symptoms as well as non-pharmacological interventions to be utilized prior to medication administration. Interview on 8/24/16, at 8:00 a.m., licensed practical nurse (LPN)-C stated R26's target behaviors were screaming, calling names and throwing water. LPN-C stated when administering a PRN medication, the reason for administration should be documented with follow-up to evaluate the effectiveness of the medication. LPN-C stated the Ativan didn't usually help. LPN-C stated there was nothing written to tell nursing whether to give the 0.5 mg or the 1 mg dose of Ativan. LPN-C stated nurses should probably have start with the 0.5 mg and if that didn't work, an additional 0.5 mg could have been administered. Interview on 8/24/16, at 8:20 a.m., registered nurse (RN)-B stated when administering a PRN medication, documentation should be completed on the back of the medication administration sheet. Documentation should include date, time, non-pharmacological interventions attempted and effectiveness. RN-B stated documentation was primarily completed on the back of the PRN medication administration record. Interview on 8/24/16, at 8:50 a.m. the assistant	F 329		

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F 329	Continued From page 31	F 329		

director of nursing (ADON) stated nursing should have documented what non-pharmacological interventions had been attempted before administering a medication. ADON stated the Ativan order should have parameters listed of when to give the 0.5 mg and when to give the 1 mg of Ativan.

An interview on 8/25/16, at 8:06 a.m. with consultant pharmacist (CP) stated the PRN Ativan was rarely used. The CP stated nursing should have documented specific symptoms or specific behaviors before administering medication. The CP would expect specific dosing parameters for behaviors to be included in the order and the lowest minimum dose should have been administered first. If an additional dose was necessary, the expectation was that nursing needed to provide documentation justifying the additional dose. The CP stated the order should include a time frame of how long to wait between doses. Per the CP, nursing staff should have documented what non-pharmacological interventions were attempted prior to administration of PRN medication. The CP confirmed this information was not included in the Ativan order and facility staff were not documenting sufficiently.

On 8/25/16, at 9:55 a.m. with director of nursing (DON) stated nursing should always start with the lowest minimum dose of medication and work up if needed. DON indicated a preference that the medication order have a specific dose versus a dose range and nursing staff should always be attempting non-pharmacological interventions prior to administration of medication.

Policy titled, "Administration of Medications" dated 5/2/14, identified, "PRN medication are to be documented in MAR (medication administration record); date, time, medication,

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F 329	Continued From page 32 dosage, route, reason and results of effect when medication given". Policy does not address when non-pharmacological interventions should be documented.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications were administered without errors for 2 of 5 residents (R18, R7) observed for medication administration. This resulted in a medication error rate of 10 percent. Findings include: R18 had been observed to receive scheduled morning medications on 8/24/16 at 7;24 a.m. by licensed practical nurse (LPN)-A while in the dining room. R18's breakfast dishes sat in front of her at the table with 95 percent (%) of her meal eaten. LPN-A administered the following medications; calcium/vitamin D, valsartan (blood pressure medication), hydrochlorothiazide (blood pressure medication), lopermide (diarrhea medication), and pantoprazole (gastro-esophageal reflux medication). R18's current physician orders read, "calcium/vitamin D 600/200 mg one tablet by mouth twice daily, valsartan 160 mg one tablet	F 332	Stewartville Care Center has policies and procedures requiring that the preparation and administration of drugs and biologicals are in accordance with 1) physicians orders 2) manufacturers specifications and 3) accepted professional standards and principles. The goal is to have a medication error rate of less than 5% and be free of all significant medication errors. The medication administration policies and procedures were reviewed and revised. The licensed nurses and trained medication aides will be required to participate in an online class addressing medication administration. During the mandatory educational meetings, the nurses will be informed of the changes in the facility s policies and procedures addressing medication administration. The nurses and trained medication aides will sign to verify review of the policies and educational material.	10/4/16

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F 332	Continued From page 33 daily, hydrochlorothiazide 12.5 mg one capsule daily, loperamide two milligrams one caplet daily, and pantoprazole 20 mg one tablet daily 30 minutes prior to breakfast. After administering R18's medication, LPN-A stated, "Oh my goodness, it does say give before breakfast. It is fairly new, I will make it a 6 a.m. [change time from 8:00 a.m. to 6:00 a .m.]." R7 received her scheduled morning medications on 8/24/16 at 7:51 a.m. by registered nurse(RN)-A. RN-A administered the following medications: oxybutynin (bladder medication), furosemide (diuretic medication), potassium chloride, vitamin B-12 one tablet, atenolol (blood pressure medication), Colace (bowel medication), Norco (controlled pain medication), Prilosec (acid-reflux medication), simethicone (gas reducing medication) chew tab, Wellbutrin SR (depression medication), metformin (diabetes medication), and Miralax powder (bowel medication) mixed in six ounces of apple juice. Surveyor stopped RN-A prior to administering medication to R7. RN-A verified she only had one tablet of vitamin B-12. After re-reading the label RN-A added a second vitamin B-12 tablet. R7 swallowed all of the tablets/caplets. R7's medication label for simethicone read; "simethicone chew 125 mg chew one tablet after meals and at bedtime for gas." Miralax label read; "mix in 8 ounces of fluid." RN-A confirmed she mixed the Miralax powder in 6 ounces of juice, not 8 ounces as the prescription label reads. RN-A stated, "She get's eight ounces [of juice] but will drink part of it."	F 332	The Assistant Director of Nurses/designee will monitor for compliance by conducting random observations of twenty percent of the nurses/trained medication aides passing medications. Observations will include medication administration for residents number 7 and 18. If an unacceptable medication error rate is noted, additional auditing and staff training will be done. Medication errors will continue to be tracked and evaluated for need for corrective action. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	

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F 332	Continued From page 34 On 08/24/16 at 10:46 a.m. the assistant director of nursing stated that medications are to be adminsitered according to the label on the medication and the medication adminsitration record. Facility policy, Administration of Medications dated 5/2/14 reads; "...2. Compare label of medication with order in medication record. Check for accuracy before administering medication."	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334		10/4/16

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F 334	Continued From page 35 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R24, R4, R17, R35, R7) were offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R24 was admitted to the facility in 12/2009, with a diagnosis of Parkinson's disease. Review of the Stewartville Care Center Immunization Record revealed refusal of the pneumovax immunization on 1/6/11. There was no additional documentation that R24 was offered the PPSV23 or the PCV13 immunizations after 1/6/2011. There was no documentation found that outlining the risks versus benefits related to refusal of the PPSV23 or PCV13 immunizations. R4 was admitted to the facility in 12/2001, with a diagnosis of schizoaffective disorder. Review of the Stewartville Care Center Immunization Record revealed R12 had received a pneumovax immunization on 10/9/2012. The immunization record lacked documentation that R4 was offered the PPSV23 or the PCV13 immunizations. R17 was admitted to the facility in 6/2014, with a diagnosis of chronic kidney disease, stage 4, and dementia with Lewy bodies. Review of the Stewartville Care Center Immunization Record revealed R17 received a pneumovax immunization on 4/1/11. The immunization record	F 334	Stewartville Care Center has developed policies and procedures to ensure that 1) each resident is offered an annual influenza immunization October 1 through March 31 and a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized 2) before offering the influenza and pneumococcal immunizations, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunizations 3) the resident or the resident's legal representative has the opportunity to refuse immunization and 4) the resident's medical record includes documentation that indicates the following: "that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations; and "that the resident either received the influenza and pneumococcal immunizations or did not receive the immunizations due to medical contraindications or refusal. The immunization related policies and procedures were reviewed and revised to include pneumococcal immunization guidelines for PPSV23 and PVC13.	

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F 334	Continued From page 37 lacked documentation that R17 was offered PPSV23 or the PCV13. R35 was admitted to the facility in 9/2015, with a diagnosis of dementia. Review of the Stewartville Care Center Immunization Record revealed R35's last pneumovax was received on 6/18/2006. The immunization record lacked documentation that R17 was offered PPSV23 or PCV13. R7 was admitted to the facility in 11/2006, with a diagnosis to include Type 2 diabetes mellitus. The facility did not provided an immunization record. On the resident Face Sheet there was documented pneumonia immunization dated 11/2003. Review of the resident's medical record revealed that R7 was not offered PPSV23, and PCV13. During the interview on 8/25/16, at 9:58 a.m. the assistant director of nursing (ADON) indicated the facility had not yet started on the revisions needed. The ADON confirmed the the policy did not include the pneumococcal 13 and 23 guidelines. The facility policy titled Resident Pneumococcal Vaccine Procedure instructed the following under sections "E": If resident was vaccinated more than 5 yrs previously, a second dose is recommended If the following occurs: has a damaged spleen or no spleen, have sickle cell disease, have HIVAIDS, have cancer, leukemia etc., have kidney failure, have nephritic syndrome, have had an organ or bone marrow transplant, or are taking any medication that lower immunities and if resident received their	F 334	During the mandatory educational meetings, the nursing staff will be instructed on the regulatory requirements and the facility□s policy/procedures addressing 1) the need to administer/offer and document the administration of influenza and pneumococcal immunizations 2) the related resident/responsible party signed notification, education, and consent and 3) the resident□s/responsible party□s right to refuse the immunizations and the need to inform them of the risks of refusal. Resident number 24 has refused the previously offered pneumovax immunizations. He will be offered the PPSV23 and PVC13. If he again refuses, he will be informed of the risks of not being immunized. Residents number 4, 17, 35 and 7 will be offered the PPSV23 and PVC13 pneumovax immunizations after approval by their physicians. If the resident/legal representative refuses, they will be informed of the risks of not being immunized. Pneumovax immunizations will be/are offered to all residents in accordance with CDC recommendations. To monitor compliance, the infection control nurse/designee will identify residents who have not had the PPSV23 and PCV13 pneumovax immunization. Their physician will be contacted for advice on the type of vaccination to administer. Compliance will be reviewed	

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F 334	Continued From page 38 first dose when they were under 65 yrs old, a second dose is recommended. This policy was not dated.	F 334	during the September and December 2016 Quality Assessment and Assurance Committee meetings.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication labels matched medication orders for 2 of 5 residents (R7, R49) observed for medication administration. Findings include:	F 425	Stewartville Care Center provides pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical	10/4/16

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F 425	Continued From page 39 R7 was observed to have her scheduled morning medications on 8/24/16 at 7:24 a.m. given by registered nurse(RN)-A. Included in R7's scheduled morning medication was Miralax powder and simethicone chew tabs. The Miralax label read: Take 17 grams (1 capful) in 8 ounces of water, juice, or soda by mouth twice daily. The physician order in the electronic medical record (entered in medical record by nursing) and medication administration (MAR) read: Miralax 17 gram in fluid twice a day. The simethicone label read: simethicone chew 125 mg, chew one tablet after meals and at bedtime for gas. The physician order in the electronic medical record and MAR read: gas relief extra strength 125 mg 1 caplet, oral, four times a day. On 9/24/16 at 9:48 a.m. RN-B verified the Miralax and simethicone orders did not match the label. R49 was administered her scheduled morning medications on 8/24/16 at 7:37 a.m. by licensed practical nurse(LPN)-A. Included in R49's scheduled morning medication was Colace. The Colace label read: Colace 100 mg take one capsule by mouth twice daily hold as needed for loose stools. The physician order in the electronic medical record and MAR read: Colace 100 mg one capsule daily hold for loose stool. LPN-A verified the label and physician order did not match. On 8/24/16 at 9:31 a.m. the assistant director of nursing (ADON) stated regarding the order and label not matching; "They should send it back to the pharmacy to have the correct label put on it.	F 425	services within the facility and to guide development and implementation of pharmaceutical services and procedures. The facility utilizes only persons authorized under state requirements to administer medications. Nurses will be comparing all medication container labels with the medication administration record (MAR). If discrepancies are noted, the medication will be returned to the pharmacy for relabeling or a sticker alerting the staff to See MAR will be attached to the medication container. During the mandatory educational meetings, the nurses and trained medication aides will be reinstructed on the need to compare the medication container label with the MAR. If there is a discrepancy the nurses/trained medication aides will 1) place a See MAR sticker on the medication container alerting the staff to check the medication administration record for changes in orders or 2) obtain a new label/container from the pharmacy. Resident number 7 □ The See MAR sticker was applied to the Miralax container to alert the staff to check the MAR for the most recent order. The resident now has a bottle of gas relief extra strength with instructions to take 1 caplet oral four times a day. The order listed on the bottle label, the physician□s order and the MAR are consistent. Resident number 49 □ The bottle of	

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F 425	Continued From page 40 The orders in the computer should be one followed." At 10:46 a.m. the ADON added, "They need to make sure the order is right and call the pharmacy to get the label to match." On 8/25/16 at 11:01 a.m. the director of nursing stated, "They have a sticky note that say 'See MAR [medication administration record]' should be applied to the label with a change. They should find the most recent order for that medication and don't administer until they find the correct order, then use the 'see MAR' sticker. Facility policy, Administration of Medications dated 5/2/14 reads; "...2. Compare label of medication with order in medication record. Check for accuracy before administering medication."	F 425	Colace has been replaced. The bottle label, physician□s order, and MAR now indicate to take one capsule by mouth daily. To ensure compliance, the nurses have checked all medication containers to ensure consistency in labeling or application of the see MAR notification sticker. The consultant pharmacist will continue to randomly check the medication storage areas for appropriate labeling of medication containers. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		10/4/16

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F 431	Continued From page 41 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications had been stored to prevent unauthorized access for 1 of 30 residents (R65) observed during stage one. Findings include: R65 was observed to be in bed n 8/22/16, at 2:31 p.m., . A container of triamcinolone cream 0.1 percent (is a topical corticosteroid by prescription) was observed to be on a counter located in R65's room. R65's treatment administration record indicated the triamcinolone cream was applied at 8:00 a.m. on 8/22/16. On 8/22/16, at 2:51 p.m., during observation, registered nurse (RN)-A confirmed the container	F 431	Stewartville Care Center provides pharmaceutical services to meet the needs of each resident. The facility has a contract with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. Drugs and biologicals are labeled in accordance with currently accepted professional standards, and include the appropriate accessary and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal	

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 42 of triamcinolone cream 0.1 percent was on a counter located in R65's room. RN-A stated the medication should be kept in the medication cart. RN-A stated R65 did not have an order to self-administer the medication. R65's physician orders, dated 8/12/16, included an order for triamcinolone acetonide ointment 0.1 percent, apply to bilateral shins twice daily. R65's treatment administration record, dated 8/16, revealed R65 was receiving the medication twice daily as ordered. On 8/24/16. At 2:26 p.m., assistant director of nursing (ADON) stated all medication should be locked in the medication cart. The ADON stated R65 did not have an order for self-administration of the medication or an order to keep the medication at the bedside. On 8/25/16, at 10:27 a.m., the director of nursing stated the nurse should not have left the medication in R65's room. The facility policy Storage of Medications, undated, indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.	F 431	laws, the facility stores all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. During the mandatory educational meeting, the nursing staff were instructed that medications not specifically indicated to be stored in the resident□s room, must be securely stored in the medication cart or be within line of sight of a person authorized to administer medications. The staff was reminded to be alert for and report any medications that the resident or family may have brought into the facility without notifying the nurse. The triamcinolone cream that was found in the room of resident number 65 has been relocated to the medication cart. To monitor compliance, the nurses will check the counters and bedside stands of residents for unauthorized medications. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		10/4/16

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F 441	Continued From page 43 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices to prevent the spread	F 441	Stewartville Care Center has established and maintains an infection control program designed to provide a safe,	

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F 441	Continued From page 44 of infection during the provision of emptying a catheter drainage bag for 1 of 2 residents (R65) reviewed for urinary catheter use and for 1 of 2 residents (R2) reviewed for urinary incontinence. Findings include: R65 HAD URINE BAG EMPTIED BUT STAFF DID NOT WASH HANDS AFTER SOILING TO PREVENT THE SPREAD OF INFECTION NOR WAS SPIGOT DISINFECTED PRE & POST HANDLING: On 8/23/16, at 1:46 p.m., nursing assistant (NA)-E was observed to apply gloves and empty the urine drainage bag as follows: pulled out the drainage spout and emptied the urine from the catheter drainage bag into a urinal. Wearing the same soiled gloves cleansed the end of the drain spout with an alcohol swab and with a different alcohol swab cleansed the holder for the drainage spout and placed the spout into the holder, picked up the chux from the floor, placed the chux into a garbage can, walked into the bathroom, emptied the urine from the urinal into the toilet, turned on the faucet, placed water into the urinal and rinsed out the urinal, pushed down on the paper towel dispenser to obtain paper towels and wiped out the inside of the urinal. NA-E then removed soiled gloves and washed hands. Nettina, Sandra M. (Ed.), (2014). Lippincott Manual of Nursing Practice, 10th Edition (p. 783). Wolters Kluwer/Lippincott Williams and Wilkins. Read, "Management of the Patient with an Indwelling (Self-Retaining) Catheter and Closed Drainage System, Procedure (continued) Nursing Action 3. Empty the bag at regular intervals,	F 441	sanitary, and comfortable environment for the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control and 4) requires staff to clean their hands after each direct resident contact for which hand cleansing is indicated by accepted professional practice. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections. Policies and procedures specific to emptying catheter bags and related glove use and handwashing have been reviewed and revised. During the mandatory educational meetings, the nursing staff were reinstructed on the infection control techniques for emptying urine collection bags and the need for hand washing when removing gloves after providing perineal care.	

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F 441	Continued From page 45 making sure that the drainage valve/spout is not contaminated. a. Wash hands; put on gloves. b. Disinfect spigot. Empty the bag in a separate collecting receptacle for each patient. Disinfect spigot again." On 8/23/16, at 2:17 p.m., NA-E verified he had not washed hands prior to the procedure of emptying R65's catheter drainage bag, failed to cleanse the drainage spout with an alcohol swab prior to draining the urine from the drainage bag and failed to remove gloves and wash hands after draining the urine from the catheter drainage bag and prior to touching other surfaces. NA-E stated he was not taught to cleanse the catheter drainage spout prior to emptying the bag, just after emptying the bag. On 8/24/16, at 2:26 p.m., the assistant director of nursing (ADON) stated the procedure for emptying a catheter drainage bag was to pull the tube out, drain the urine from the bag into a urinal, use an alcohol swab to cleanse the tip off or the drain spout and place the drain spout put back in the holder. When queried what the facility policy was for emptying a drainage bag, ADON-G reviewed the policy and stated the drain spout should be cleansed with an alcohol swab before draining the urine from the bag. The ADON stated, regarding removing gloves and washing hands after draining urine from the catheter drainage bag, she expected gloves to be removed and hands washed right away. On 8/25/16, at 10:27 a.m., the director of nursing stated the procedure for emptying a catheter drainage bag was gather supplies, wash hands, apply gloves, cleanse the drainage spout before emptying the urine from the bag and after	F 441	Certified nursing assistants will be observed for correct infection control techniques when emptying the catheter bag for resident number 65. Resident number 2 was receiving hospice services and died at the facility September 2, 2016. Compliance will be monitored by the Assistant Director of Nurses/designee through direct observation of the certified nursing assistant providing catheter cares. The certified nursing assistants will review written procedures for emptying a urine collection bag, sign to verify they understand the information, and then demonstrate the technique to a licensed nurse. The charge nurses will randomly observe for proper gloving and handwashing during perineal cares for 7 days. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	

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F 441	Continued From page 46	F 441		

emptying, empty the container the urine is in, rinse the container, remove gloves and wash hands.

A policy for emptying a catheter drainage bag was requested, but not provided.

R2 RECEIVED PERINEAL CARES HOWEVER, STAFF DID NOT CHANGE SOILED GLOVES AFTER CLEANSING BUTTOCKS OF URINE AND STOOL TO PREVENT THE SPREAD OF INFECTION:

During observation on 8/23/16, at 4:28 p.m., nursing assistant (NA)-G and NA-F entered R2's room. NA-G applied gloves, pulled down R2's incontinent product (visibly soiled with urine and bowel movement), and cleansed the front of R2's perineal area, which was soiled with visible bowl movement. Wearing the soiled gloves NA-G assisted to roll R2 over, applied a clean incontinent product, pulled up R2's pants and place a sling under R2. NA-G then removed soiled gloves and washed hands.

On 8/23/16, at 4:43 p.m., NA-G verified the above. NA-G stated she probably should have changed gloves and washed hands after cleansing R2's perineal area.

On 8/25/16, at 10:31 a.m., the director of nursing stated he expected after providing perineal caress, staff should remove gloves and wash hands.

The facility policy Hand Washing, undated, indicated purpose was to reduce transmission of organisms from resident to resident, nursing staff to resident and from resident to nursing staff.

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F 441	Continued From page 47 Procedure: C. Wash your hands before and after all procedures. The facility policy Standard Precautions, undated, Procedure: 1. Hand washing a. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. b. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to the other residents or environments. 2. Gloves c. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		10/4/16

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F 514	Continued From page 48 Based on interview, and document review, the facility failed to ensure current physician orders were retained in the medical record for 1 of 5 residents (R7) to check for accuracy of medications given to the residents. Findings include: R7's physician orders located in the electronic medical record (EMR) which were entered by nursing staff failed to match medication labels for Miralax powder and simethicone chew tablets. On 8/24/16 at 9:31 a.m. the assistant director of nursing (ADON) was asked to locate the original physician orders for R7. The ADON stated, "I doubt the paper copy is in the chart. It should be in the chart [EMR], scanned in." The ADON searched the paper chart, electronic record, and files at the nurses station. The ADON was unable to locate the original physician order for R7. On 8/24/16 at 9:48 a.m. registered nurse(RN)-B described the process of entering physician orders, "You write it down, send it into pharmacy, stamp faxed, and enter it in the computer [EMR], and write it in on the MAR [medication administration record]. I put it in the folder for business office to scan and then the original goes in the chart. MR [Medical Records] creates the orders to be signed by the physician for rounds." On 8/24/16 at 10:03 a.m. MR was unable to locate original current physician orders for R7's Miralax or simethicone. At 1:03 p.m. MR added "I found where the doctor ordered the Gas-X [simethicone] on 2/18/10, That is all I could find on the Gas-X. I found the written order for Miralax ordered 7/1/10." Written order for Miralax reads,	F 514	Stewartville Care Center maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. The clinical record is used as a communication tool to manage and track the resident□s progress in maintaining or improving functional abilities and psychosocial well-being. The record contains an accurate representation of the actual experience of the individual in the facility with documentation providing a picture of the resident□s progress/status, response to medications/treatments, changes in condition, and necessary modifications of the plan of care to facilitate meeting the residents□ goals. The policies and procedures for processing and uploading physician/nurse practitioner orders into the electronic medical record system were reviewed and revised. During the mandatory educational meetings, the licensed nurses will be reinstructed on the policies and procedures for electronic processing of physician/nurse practitioner orders and the requirement for maintaining a signed paper or electronic copy of all orders. For resident number 7, the physician□s order for Gas Relief Extra Strength (simithicone) four times per day was found to be consistent with the label on the medication container and the	

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F 514	Continued From page 49 "Miralax 17 grams in 4 - 8 ounces of water every day for chronic constipation." The current order entered in the electronic medical record read, "Miralax 17 gram in fluid. If no BM [bowel movement] in six days, then may use 1 bottle of mag [magnesium] citrate." The ADON, RN-B, or MR was unable to clarify which Miralax order was to the correct physician order to use. On 8/25/16 at 10:04 a.m. the pharmacist for Weber & Judd stated how orders are received from the Stewartville Care Center. Pharmacist-A said, the nursing home has the doctors order, they fax it to the pharmacy, and the home keeps the original physician orders. Pharmacist-A said they wouldn't set up medications exactly as the physician wrote the order. If the order is changed we would need the nursing home to send us another fax before we change the prescription first ordered by the physician. On 8/25/16 at 10:30 a.m. the consultant pharmacist stated, "The original physician order should be somewhere to go back to reference. I know they have problems with thinning the chart." On 8/25/16 at 11:01 a.m. the director of nursing (DON) stated re: physician orders; "If it is on a recertification they have a print out the nurse practitioner will just change it to whatever they want. The original order would go to MR and put in the chart and thinned at whatever intervals she thins out." A facility policy regarding medical record retention was requested, but not provided.	F 514	medication administration record. An updated order allowing nursing judgement in the amount of fluid to administer with Miralax will be obtained. Compliance will be monitored for seven days by the Medical Record Coordinator through random checks of the accuracy of orders listed on the electronic log. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the September and December 2016 Quality Assessment and Assurance Committee meetings.	

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	245349	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/25/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 8/25/2016, Stewartville Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2016

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Stewartville Care Center is a 2-story building. The building was constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 1976, addition was constructed and was determined to be of Type II(111) construction.

Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 57 beds and had a census of 35 at the time of the survey.

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K 000	Continued From page 2	K 000		
K 027 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7. On facility tour between 10:00 AM and 12:30 PM on August 25, 2016, based on observation and interview revealed that the smoke compartment door in the North wing did not close when tested. This deficient practice could affect the safety of the (10) residents within the smoke compartment.	K 027	The Maintenance Supervisor had door repaired 08/25/2016 so it would not stick due to high humidity. The Maintenance Supervisor will check fire doors during fire drills to ensure proper functioning.	8/25/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (DH) at the time of discovery.	K 027		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 On facility tour between 10:00 AM and 12:30 PM on August 25, 2016, based on observation and interview revealed that an extension cord was found at reception desk by front door.. This deficient practice could affect the safety of the residents in the lobby area. This deficient practice was confirmed by the Facility Maintenance Director (DH) at the time of discovery.	K 147	The Maintenance Supervisor removed extension cord in question on 08/25/2016. The Maintenance Supervisor will look for and remove any non-approved extension cords in his daily rounds on-going.	8/25/16