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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XWC1
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 **05/27/2014** (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 **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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):
CCN-24-5349
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on May 27, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date : 05/29/2014
Gary Nederhoff, Unit Supervisor (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 06/05/2014
Kamala Fiske-Downing, Enforcement Specialist (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

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245349 June 6, 2014

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

Dear Mr. Gustason:

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

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

Effective May 20, 2014 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all85 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2014

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

RE: Project Number S5349024

Dear Mr. Gustason:

On April 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2014 that included an investigation of complaint number H5349021. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 20, 2014 and therefore remedies outlined in our letter to you dated April 25, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245349	A. Building B. Wing	5/27/2014

Name of Facility	Street Address, City, State, Zip Code
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	05/20/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	05/20/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	05/20/2014
ID Prefix F0371 Reg. # 483.35(i) LSC	05/20/2014	ID Prefix F0428 Reg. # 483.60(c) LSC	05/20/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	05/20/2014
ID Prefix F0441 Reg. # 483.65 LSC	05/20/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/10/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XWC1

Facility ID: 00429

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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 **04/10/2014** (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 **85** (L18)

13.Total Certified Beds **85** (L17)

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X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 04/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/05/2014 (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
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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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5349

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 25, 2014

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

RE: Project Number S5349024

Dear Mr. Gustason:

On April 10, 2014, 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. In addition, at the time of the April 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5349021.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**

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

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

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

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (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 July 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 10, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 July 10, 2014 (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 October 10, 2014 (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
Division of Compliance Monitoring
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING ______ B. WING ______	04/10/2014

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. 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 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. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5349021 was completed. The complaint was not substantiated.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 6 of 9 residents (R35, R37, R33, R14, R60, and R69) who ate in the main dining room and required assistance to eat their meals. Findings Include:	F 241	Stewartville Care Center promotes care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The staff routinely interact with residents and provide high quality care and	5/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/05/2014

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 ______	04/10/2014

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 241	Continued From page 1 R35 was observed during the of the evening meal experience on 4/7/14 starting at 5:40 p.m. R35 was sitting in a Geri-chair, (a reclining chair with wheels that is not self-propelled), at a table designated for residents who need assistance with eating with pureed food set in front of her at 5:40 p.m. Her meal was left uncovered and no staff was observed to assist R35 from the time the food was put on the table at 5:40 until 5:55 p.m. (fifteen minutes later) a staff member came up to the resident and gave her bites of food. It was observed that the staff member stood next to her Geri-chair while feeding her. R35 was admitted on 12/15/08 according to the physician ' s orders. The physician visit dated 3/19/14 indicated R35 had the diagnoses of Dementia, Alzheimer's Type, epilepsy and that R35 does not respond to questions. The signed physician orders dated 3/19/14 indicated that R35 was on a pureed diet and was to receive nutritional supplement of 2-4 ounces three times a day due to low oral intake. The care plan dated 3/18/14 indicated R35 needed to be fed totally related to her dementia and indicated R35 had short and long term memory problems related to advanced dementia and that the Brief Interview for Mental Status (BIMS) was not able to be completed. The annual Minimum Data Set dated 3/4/14 indicated R35 was totally dependent on staff for all activities of daily living. R37, R60, R33, R69, and R14, were observed during a dining experience on 4/8/14 starting at 5:00 p.m. R37 and R60 were seated at the same table in the main dining room. R33 and R69 were seated together at a table and R14 was seated at a different table. R33 received her food at 5:40 p.m. and made no attempts to eat or drink	F 241	supportive services that meet their needs as identified in the comprehensive assessment and outlined in the plan of care. The staff strive to provide an environment that maintains and enhances the resident's self-esteem and self-worth. Assistance with activities of daily living is provided with the goal of maximizing resident function and satisfaction. The policies and procedures for assisting residents during meal time were reviewed and revised with the goal to further enhance the residents' dining experience. The meal delivery process and dining room seating were assessed by the dietary and nursing supervisory staff with focus on residents requiring eating assistance including residents number 35, 37, 60, 33, 69, and 14. During the mandatory meetings April 29, 30, and May 1, 2014, the nursing staff were instructed to 1) adhere to scheduled break times to assure adequate staff are available to assist residents during meal time 2) assist residents with eating at the time the food is served to them 3) sit next to the resident when assisting with eating and engage him/her in resident-centered conversation and 4) notify the charge nurse if additional staff are needed to assist residents with eating. The staff were reminded of the residents' right to dignified and respectful treatment with an emphasis on a therapeutic and pleasurable dining experience. The Staff Development Coordinator will	

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F 241	Continued From page 2 independently. Nursing assistant (NA)-B was observed to be sitting at the other end of the table from R33 however, made no attempts to talk to, cue or encourage R33 to eat. R33's spouse started to feed her bites of her food at 5:47 p.m. At 5:52 p.m. NA-A was assisting R14 to eat and asked NA-B if anybody was helping R33 to eat. NA-B stated, "No, I am feeding these two." NA-A left the table where she was assisting R14 with the meal and approached R33 to assist her with the meal. NA-A stood to the left side of R33 and assisted her to eat. At 5:51 p.m. R37 received her meal and when NA-B assisted her to eat the meal she stood to the right of R37 and gave resident bites of her food. During this interaction NA-B was not observed to speak or interact with R37. At 5:57 p.m. NA-A left R33 to continue to assist R14 with his meal. NA-A proceed to walk back and forth between the tables to assist both residents with their meals. At 5:59 p.m. R60 received her food and NA-A was observed to be going back and forth between three residents at separate tables assisting R14, R33 and R60 to eat their meals. R37's nutritional status care plan dated 3/27/14 indicated she was on a general diet with no restrictions. Per family preference would receive soft foods. The eating care plan dated 7/15/13 noted R37 was usually able to feed self after setup was provided. R37 sat at the assisted table per family request and feed self and was supervised. Some days R37 would need staff to finish her meal by feeding her related to inattention or fatigue. R33's nutritional status care plan dated 2/26/14 indicated she was on a liberal geriatric diet (LGD) with no restrictions. The eating care plan dated	F 241	continue to instruct new employees on residents' right to dignified care and services as part of the orientation process. The residents' right to respect and dignity is also addressed during the annual employee education/training. The dietary manager will monitor compliance by evaluating the meal delivery practices and by observing staff who are assisting resident with eating for proper technique. Three meals per week will be monitored for one month. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed during the June quarterly Quality Assurance and Assessment Committee meeting.	

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F 241	Continued From page 3 9/5/13 noted, Strength: R33 was usually able to feed herself and does especially well with finger foods. R33 may need staff to assist her at times with eating, to be prompted to finish her meals, and to take fluids and snacks when offered. R14's nutritional status care plan dated 4/1/14 indicated he was on a general diet with no restrictions. The eating care plan dated 4/1/14 noted, Strength: R14 was usually able to feed some himself independently. But with his decline he has needed staff to assist him more. R60's nutritional status care plan dated 2/13/14 indicated she was on a general diet with no restrictions, was often distracted at meals and needed to be encouraged and redirected. R69's nutritional status care plan dated 4/1/14 indicated she was on a LGD with no restrictions. The eating care plan dated 7/12/13 noted, Strength: R69 was rarely able to feed self after setup is provided due to her cognitive impairment. R69 had difficulty following cues. R69 would at times feed herself when given finger foods. Due to her dementia staff may need to feed her when she is unable, and she now has a mechanical soft diet. During an interview on 4/8/14 at 6:02 p.m. the licensed social worker (LSW)-A verified NA-A was assisting five residents at three different tables during the time of our interview. LSW-A verified there were currently 9 residents in the dining room that required assistance to eat and there were three staff members to provide the assistance. LSW-A verified when NA-A left one resident to help a resident at a different table it interrupted each resident's meal experience. LSW-A verified if NA-A was not helping the five residents at the same time all residents needing	F 241		

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F 241	Continued From page 4 assistance would not have been helped to eat their meals that had been placed in front of them. During an interview on 4/10/14 at 9:33 a.m. the director of nursing (DON) stated he expected staff to sit down by a resident to assist them with their meal as soon as the food was delivered to the resident as this was good practice. The DON verified staff should not assist residents with eating at three different tables at the same time. The DON verified residents should not receive their plate of food until there were staff members that were able to assist them to eat. The DON stated NA-A should have asked for assistance to help in the dining room instead of assisting five residents to eat their meals at three different tables. These comments were made in regards to the observations of R35, R37, R33, R14, R60, and R69. The DON was requested to provide a policy on feeding residents, however none was provided.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive resident centered care plan was followed for fall precautions as directed by the plan of care for 1 of 3 residents (R48) reviewed	F 282	Stewartville Care Center assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in	5/20/14

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F 282 Continued From page 5
for accidents.

Findings included:

R48's resident admission record dated 4/10/14, identified R48 had been admitted on 6/10/2013 with diagnoses that included but were not limited to paralysis agitans-Parkinson, osteoarthrosis, pain generalized and history of falls.

The current plan of care dated 8/9/13, indicated R48 had greater than normal risk for falls secondary to Parkinson's, debility and fall history with interventions of but not limited to, per therapy recommendations have Reacher available to use when R48 in room by self, one-way glide in wheelchair and recliner and anti-slip pads to be used in recliner chair and wheelchair.

During observation on 4/9/14, at 12:43 p.m., R48 had been in room by self, sitting in wheelchair and Reacher (hand held device used to grab items that are not in reach of arm/hands) had been hanging off cupboard counter top out of R48's use. Licensed practical nurse (LPN)-B entered R48's room and assisted to transfer R48 from wheelchair to bed using a total mechanical lift. R48's Reacher had remained hanging off cupboard counter top out of R48's use after R48 had been transferred into bed and LPN-B had walked out of R48's room. LPN-B verified at the time there had been no anti slip pad in recliner or wheelchair and no one-way glide in R48's room for use.

During interview on 4/9/14, at 1:06 p.m., LPN-B had stated director of nursing (DON) was going to get an anti-slip pad and one way glide for R48's use. At 1:19 p.m., LPN-B brought one-way glide

F 282

accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

The procedures for communicating the residents' care needs to the direct care staff were reviewed and found appropriate. During the mandatory meetings April 29, 30 and May 1, 2014, the direct care staff were instructed 1) to check the "24-hour Report Sheets" to verify the types of enabling/assistive/ safety devices used by the resident 2) how to access the electronic care plan verify/clarify use of devices and 3) to check with the charge nurse if there are questions regarding the resident's care or use of equipment/devices. The staff was reminded that the resident care plans must be followed and that job performance expectations include being aware of and following the care plan including the plan for resident number 48 which specifies use of the extended reach device, the anti-slip pad and the one-way seat glide.

Compliance with use of enabling/safety devices will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will

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F 282	Continued From page 6 and anti-slip pad to R48's room. During interview on 4/10/14, at 11:32 a.m., DON stated he would expect fall interventions to be followed as R48 is very impulsive.	F 282	be assigned by the Director of Nurses/designee at least twice weekly for one month. If noncompliance is noted additional monitoring and staff training will be done. Compliance will be reviewed at the June 2014 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 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:	F 329		5/20/14

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F 329	Continued From page 7 Based on interview and record review, the facility failed to adequately and clearly identify indications (resident specific symptoms) for use of an anti-anxiety and anti-psychotic medications for 1 of 5 residents (R52) and the facility failed to offer non-pharmacological interventions prior to giving as needed (PRN) pain medications and failed to consistently document reason/s medication was given and effectiveness of prn pain medications for 1 of 5 residents (R64) reviewed for unnecessary medications. Findings include: R52 had been admitted on 1/8/12. R52's resident admission record undated identified diagnoses of but not limited to delusional disorder, cognitive impairment mild, anxiety state and depressive disorder. R52's quarterly Minimum Data Set (MDS) dated 2/12/14, identified brief interview of mental status (BIMS) had been 13 out of 15 and indicated cognitively intact and no behaviors. Document review of R52's physician orders dated 3/19/14, identified an order for Xanax (alprazolam) (an anti-anxiety medication) 0.25 mg (milligrams) BID (twice a day) and Seroquel (quetiapine) (an anti-psychotic medication) 25 mg Q HS (at bedtime). Document review of R52's behavior/intervention monthly flow record dated April 2014, identified behaviors of anxious, excessive worrying and psychoactive drug/dose of Seroquel and Xanax. R52's care plan problem start date 6/3/13, identified psychotropics: has diagnosis of depression, anxiety and delusional disorder, on medication daily for delusional disorder, use of	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 staff, 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. Based on the resident s comprehensive assessment, Stewartville Care Center staff routinely identify target behaviors that justify the use of psychotropic medications. An effort is made to simplify medication regimens and discontinue psychotropic medications whenever possible. Guidelines/parameters are developed when analgesics or psychotropic medications are prescribed on an as needed (PRN) basis. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licenses nurses and the social worker. The	

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Continued From page 8

antipsychotic medication puts at increased risk for fall and goal of will have no increased symptoms of depression or anxiety.

During interview on 4/10/14, at 11:37 a.m., director of nursing stated very broad with identified behaviors of anxious and excessive worrying, he would expect it to be more specific with what worried and anxious about means.

Document review of the facility policy psychotropic medications dated revised 3/2013, read, " III. PROCEDURE: F. Behavior monitoring sheet will be placed with residents (sp) medication record in the med book and licensed staff will assess behavior on a shift-to-shift basis according to specific targeted behavior and frequency this behavior occurred per shift."

R64 had been admitted on 10/09/12 according to the Admission record dated 4/10/14 also identified diagnosis of but not limited to pain in joint shoulder. R64's quarterly MDS dated 3/5/14, indicated R64 received scheduled pain medication, received no PRN medication, received no non-pharmacological interventions for pain, frequency of pain almost constantly and verbal descriptor severe.

During review of R64's current physician orders dated 3/4/14, revealed an order for Norco (hydrocodone-acetaminophen) (a pain medication) 5-325 mg (milligrams), two tablets TID (three times a day) and may have two tablets PRN QD (everyday).

During review of R64's care plan problem start date 9/23/13, identified problem of pain and arthritis, has scheduled and PRN medication for

F 329

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. A behavior monitoring log is used to identify and quantify target behaviors justifying antipsychotic and antianxiety medication use.

During the mandatory meetings April 29, 30 and May 1, 2014, the licensed staff were instructed to 1) identify specific target behaviors that justify use of a psychotropic medication 2) offer nonpharmacological interventions to manage pain prior to giving an as needed (PRN) analgesic and 3) record the resident s response to administration of the PRN analgesic. A reference list of nonpharmacological interventions for pain control will be filed in the medication administration notebook.

Resident number 52 The resident s history of behavior symptoms was reviewed. The resident was admitted on January 18, 2012 with an order for Xanax for depression. The social worker note from the February 7, 2012 interdisciplinary care conference states, Resident had no nursing care concerns. Resident reports feeling anxious frequently throughout the day, family and resident requested an anxiety medication to assist. The nurse practitioner s (NP) 2/9/12 progress notes indicate a diagnosis of anxiety and states,

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F 329	Continued From page 9 pain, areas most affected are left arm/shoulder and directed nursing to administer pain medication as ordered and monitor for effectiveness. During review of R64's PRN medications flow sheet and PRN medication notes the following had been noted: from the dates of 2/1/14 through 2/28/14 R64 had had received a total of 11 doses of PRN Norco, from the dates of 3/1/14 through 3/31/14 R64 had received 10 doses of PRN Norco, from the dates of 4/1/14 through 4/5/14 R64 had received 4 doses of PRN Norco with no documentation of non-pharmacological interventions, reasons given and effectiveness consistently documented. On 4/10/14, at 11:24 a.m., Licensed practical nurse (LPN)-B verified the above. During interview on 4/10/14, at 11:49 a.m., director of nursing stated he would expect non-pharmacological measures to be offered, reasons for giving and effectiveness to absolutely be documented for PRN pain medication. Requested policy for PRN pain medications at the time from director of nursing, none had been provided.	F 329	the resident feels the anxiety is due to pain. Since the resident was on an aggressive pain management program and often told the nurse she had little or no pain, the NP increased the resident s Xanax from two times per day to three times per day in an attempt to decrease her anxiety. The resident s behaviors included repetitive requests for pills in spite of the successful pain management program, unfounded distress about her husband s welfare as well as paranoid ideations regarding family members. The resident s symptoms of anxiety continued to increase. The March 22, 2012 nurses notes state, Seen by NP . . . Resident has been very anxious and delusional, as in looking for her parents, thinking someone is going to kill her. She calls her husband and family members repeatedly. Order written for Seroquel 25 mg for delusional disorder. Resident agitated and confused entire shift, continues to want to go home, talk to her parents, makes statement such as she wants us to get the meat and other nonsensical statements. Res wants to go to her room, staff brings her to her room and she follows them out and asks the next person to bring her to her room, this went on for quite some time. Continues to phone husband repeatedly, heard her yelling and when I went in she handed me the phone and said, my father wants to talk to you , her husband was on the phone and very upset. Husband stated that she repeatedly called him and now he was so nervous that he wouldn t be able	

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F 329	Continued From page 10	F 329	to get back to sleep and that she can t call him over and over again, he was very upset and wanted phone taken out of her room. A March 23, 2014 nurse s note states, Resident s granddaughter spoke to me re. resident s increased anxiety. Resident calls her husband many times a day and at time will tell him that they are killing me and asks him to come and get her. (Granddaughter) was informed of the new order for Seroquel. On November 8, 2012, Xanax was reduced from three to two times per day. The resident s behavior monitoring flow sheet will be revised to include more specific behaviors related to the resident s anxiety and delusions such as repetitive vocalizations indicating distress, frequent requests for and concern about pain medications in absence pain symptoms, paranoid fear of harm, and statements that she is feeling anxious. The physician will be notified of significant changes in the resident s behaviors/mood. The care plan has been updated accordingly. Resident number 64 - The resident s pain management was reassessed. The resident can accurately and consistently identify pain and request analgesics. A May 1, 2014 nurses s note states, Resident was seen by Dr. . . physician aware that resident frequently refuses or resists care, vital signs, blood sugar checks, insulin and other meds. Narco	

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F 329	Continued From page 11	F 329	changed to PRN as she frequently won t take it as scheduled and meds are wasted. The nurse s notes reflect use of Ben Gay and hot packs for pain relief. The care plan will be updated to include nonpharmacological interventions. To monitor compliance, for one month the Director of Nursing/designee will audit records for specificity of target behaviors justifying psychotropic medication use and the documentation related to the administration of PRN pain medications with a focus on nonpharmacological interventions and the residents response to the analgesic. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the June Quality Assessment and Assurance meeting.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to date and label open	F 371	Stewartville Care Center stores, prepares, distributes, and serves food	5/20/14

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

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F 371	Continued From page 12 food packages; failed to monitor temperatures for foods stored in a standing refrigerator and one combination side by side standing refrigerator and freezer; failed to maintain clean ovens used to cook food and failed to ensure dish washer temperatures were within acceptable ranges for adequate sanitation. This had the potential to affect 73 of 74 residents who received food prepared from the kitchen. Findings include: During initial tour of kitchen and kitchenette downstairs on 4/7/14, at 1:29 p.m., dietary manager verified at the time one bag each of peas, oriental vegetables and mixed vegetables had been opened with no label and date opened on a shelf in the walk in freezer. Dietary manager stated the bags of vegetables should be stored in the box originally came in with expiration date or placed in a container with label and date opened. One standing refrigerator in main kitchen had no temperature log, dietary manager stated at the time temperatures not recorded unless an issue. One combination side by side standing refrigerator and freezer in the kitchenette downstairs had no temperature log for the refrigerator or freezer temperatures. Dietary manger stated at the time we do not record the temperatures. During observation on 4/9/14, at 11:23 a.m., two ovens had tinfoil laid on the bottom of each oven and had been heavily soiled with food spill build up. Dietary aide-B verified at the time and stated food had been cooked in one oven today. Dietary aide-B had stated we are trying to clean the ovens every two weeks but we are having staffing issues.	F 371	under sanitary conditions. The Food Storage and Issue policy was reviewed and updated. A new Refrigerator/Freezer Temperature Recording policy was developed. The Mechanical Dishwashing and Cleaning/Maintenance policies were reviewed and found appropriate. During the May 1, 2014 mandatory training meeting, the dietary staff were instructed on the policies for food storage with a focus in the labeling of open food packages, monitoring of refrigerator/freezer temperatures, the schedule/procedure for cleaning the ovens, and acceptable dishwasher water temperatures and monitoring the water temperatures. Compliance with policies will be monitored by the dietary manager as follows: 1) food storage areas will be monitored twice weekly for proper storage/labeling 2) freezer/cooler temperature record sheets will be audited twice weekly for four weeks, once weekly for four weeks and monthly thereafter 3) the oven cleaning schedule will be reviewed weekly and the ovens checked for cleanliness weekly and assessed for as needed cleaning between scheduled cleanings and 4) the dishwasher water temperatures will be randomly audited prior to initiation of washing five times per week for two weeks, twice per week for two weeks, and monthly thereafter. If noncompliance is noted, additional monitoring and staff	

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F 371	Continued From page 13	F 371	education will be done. Compliance will be reviewed at the June 2014 Quality Assessment and Assurance Committee meeting.	

Document review of the facility daily/weekly cleaning schedule start date of 3/25/14, revealed ovens had not been cleaned from 3/25/14 through 4/5/14.

During observation on 4/9/14, at 11:45 a.m., dietary aide-A had washed a load of dishes in a hot water sanitation only dishwasher. Rinse cycle had reached 167 degrees at the manifold. Dietary aide-A washed second load of dishes and rinse cycle had reached 171 degrees at the manifold. Surveyor had to intervene and stop dishes from being used. Dietary aide-A verified rinse cycle temperatures at the time of observation. Dietary aide-A stated at the time, " I don't know what I would do with the dishes if the temp of the dishwasher does not reach right temp. I've never been told what to do with the dishes if not right temp."

During interview on 4/10/14, at 937 a.m., dietary manager had stated she would expect if items opened, not dated and labeled would have to be thrown away, when food containers opened needs to be in labeled container and dated and if expiration date is on box item comes in put that on there. Dietary manager had stated she would expect monitor logs of refrigerator and freezer temperatures; we have overlooked tracking temps of refrigerators and freezers and are putting a system into place. Dietary manager stated cleaning ovens usually cleaned weekly of bi-weekly, but has not been getting done in last two weeks. Dietary manager had stated probably have to do education on dishwasher temperatures, temperatures have to be up to temp (180 degrees at manifold or 160 at rack level/dish surface) before sanitation of dishes and

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F 371	Continued From page 14 need to keep re-washing same load until reach right temperature or run dishwasher empty until temperature is reached. Document review of the facility policy FOOD STORAGE-PERISHABLE dated revised 3/11/14, read " III. PROCEDURE: j. The remaining contents of opened food packages will be stored in a labeled plastic container with a tight fitting lid." Document review of the facility policy STORAGE AND ISSUE dated revised 3/11/14, read " III. PROCEDURE: d. Temperature records will take place on a daily basis. Elevated temperatures will be immediately brought to the attention of the CDM and maintenance staff." Document review of the facility policy DIETARY DEPARTMENT CLEANING & MAINTENANCE dated revised 3/24/14, read " III. PROCEDURE: B. Weekly/Monthly Cleaning will be completed by designate cleaning employees and recorded on cleaning schedule. v. Conventional Oven will be cleaned monthly, or as needed." Document review of the facility policy MECHANICAL DISHWASHING PROCEDURE dated revised 3/26/13, read,"PROCEDURE: a. Fill dishwasher with water. Check Temperatures to insure wash water is 150-160?F and rinse water is 180?F. Run machine to ensure appropriate temperature, before washing. Record temperature."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		5/20/14

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F 428	Continued From page 15 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the consultant pharmacist identified lack of indications for use of an anti-anxiety and anti-psychotic medications for 1 of 5 residents (R52) and failed to identify lack of non-pharmacological interventions prior to giving as needed (prn) pain medications and lack of reasons given and effectiveness of prn pain medications for 1 of 5 residents (R64) reviewed for unnecessary medications. Findings include: R52 had been admitted on 1/8/12. R52's resident admission record undated identified diagnoses of but not limited to delusional disorder, cognitive impairment mild, anxiety state and depressive disorder. R52's quarterly Minimum Data Set (MDS) dated 2/12/14, identified brief interview of mental status (BIMS) had been 13 out of 15 and indicated cognitively intact and no behaviors. Document review of R52's physician orders dated 3/19/14, identified an order for Xanax (alprazolam) (an anti-anxiety medication) 0.25 mg (milligrams) BID (twice a day) and Seroquel	F 428	The goal of Stewartville Care Center is to maintain the resident s highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon. The Director of Nursing and Consultant Pharmacist reviewed the facility s policies and procedures for tracking target behaviors, documenting nonpharmacological interventions to manage pain, and recording the residents response to as needed (PRN) analgesics. The pharmacist will continue to review records on a monthly basis and routinely check for appropriate indications justifying psychotropic medications and documentation showing the resident s response to PRN analgesics.	

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F 428	Continued From page 16 (quetiapine) (an anti-psychotic medication) 25 mg Q HS (at bedtime). Document review of R52's behavior/intervention monthly flow record dated April 2014, identified behaviors of anxious, excessive worrying and psychoactive drug/dose of Seroquel and Xanax. R52's care plan problem start date 6/3/13, identified psychotropics: has diagnosis of depression, anxiety and delusional disorder, on medication daily for delusional disorder, use of antipsychotic medication puts at increased risk for fall and goal of will have no increased symptoms of depression or anxiety. During interview on 4/10/14, at 11:37 a.m., director of nursing had stated very broad with identified behaviors of anxious and excessive worrying, he would expect it to be more specific with what worried and anxious means. Facility consultant pharmacist-C had been contacted on 4/10/14, at 1:15 p.m. by telephone, message left for return call. No return call had been received. R64 had been admitted on 10/09/12. R64's resident admission record dated 4/10/14, identified diagnosis of but not limited to pain in joint shoulder. R64's quarterly Minimum Data Set (MDS) dated 3/5/14, indicated R64 received scheduled pain medication, received no PRN (as needed) medication, received no non-medication interventions for pain, frequency of pain almost constantly and verbal descriptor severe. During review of R64's current physician orders dated 3/4/14, revealed an order for Norco	F 428	During the mandatory meetings April 29, 30 and May 1, 2014, the licensed staff were instructed to 1) identify specific target behaviors that justify use of a psychotropic medication 2) offer nonpharmacological interventions to manage pain prior to giving a PRN analgesic and 3) record the resident s response to administration of the PRN analgesic. Resident number 52 The resident s history of behavior symptoms was reviewed. An anti-anxiety medication was prescribed after the resident requested something for her anxiousness and the daughter expressed concerns about her mother s anxiety. The resident was refusing cares/medications and was restless with repetitive requests/actions from which she could be only momentarily distracted/redirected. An antipsychotic medication was subsequently prescribed for increasing delusions and paranoid ideations. The resident s behavior monitoring flow sheet will be revised to include more specific behaviors related to the resident s anxiety and delusions such as repetitive vocalizations indicating distress, frequent requests for and concern about pain medications in absence pain symptoms, paranoid fear of harm, and statements that she is feeling anxious. The physician will be notified of significant changes in the resident s behaviors/mood. The care plan has been updated accordingly.	

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Continued From page 17

(hydrocodone-acetaminophen) (a pain medication) 5-325 mg (milligrams), two tablets TID (three times a day) and may have two tablets PRN QD (everyday).

During review of R64's care plan problem start date 9/23/13, identified problem of pain and arthritis, has scheduled and PRN medication for pain, areas most affected are left arm/shoulder and directed nursing to administer pain medication as ordered and monitor for effectiveness.

During review of R64's PRN medications flow sheet and PRN medication notes the following had been noted: from the dates of 2/1/14 through 2/28/14 R64 had had received a total of 11 doses of PRN Norco, from the dates of 3/1/14 through 3/31/14 R64 had received 10 doses of PRN Norco, from the dates of 4/1/14 through 4/5/14 R64 had received 4 doses of PRN Norco with no documentation of non-pharmacological interventions, reasons given and effectiveness consistently documented. On 4/10/14, at 11:24 a.m., Licensed practical nurse (LPN)-B verified the above.

During interview on 4/10/14, at 11:49 a.m., director of nursing had stated he would expect non pharmacological measures to be offered, reasons for giving and effectiveness to absolutely be documented for PRN pain medication. Requested policy for PRN pain medications at the time from director of nursing, none had been provided.

Facility consultant pharmacist-B had been contacted on 4/10/14, at 1:15 p.m. by telephone, message left for return call. During interview on

F 428

Resident number 64 - The resident can accurately and consistently identify pain and request analgesics. The nursing staff have been reminded to continue to offer nonpharmacological interventions to relieve pain and to document the resident s response to pharmacological and nonpharmacological interventions. The care plan will be updated to include nonpharmacological interventions to relief pain.

To monitor compliance, for one month the Director of Nursing/designee will audit records for specificity of target behaviors justifying psychotropic medication use and documentation related to the administration of PRN pain medications. The consultant pharmacist will continue to routinely monitor records for identification of target behaviors, nonpharma-cological pain management interventions, and the residents response to PRN analgesics. Compliance will be reviewed during the June quarterly Quality Assessment and Assurance meeting and ongoing.

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F 428	Continued From page 18 4/12/14, at 12:47 p.m., facility consultant pharmacist-B had stated she would expect residents who express pain be offered non-pharmacological measures, also reasons for giving medication and effectiveness of PRN pain medications to be documented.	F 428		
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 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	F 431		5/20/14

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F 431	Continued From page 19 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 document review, the facility failed to ensure that only authorized personnel had access to 1 of 2 medication storage rooms, and the facility failed to provide safe and secure medication storage of narcotics in 1 of 2 of medication storage rooms. This had the potential to affect all residents who required medications from the emergency kit. Findings include: On 4/9/14, at 4:38 a.m. a key ring with multiple keys were observed hanging in the key hole in the main level medication storage room door knob. The storage room was located between the nurse station and dining room entry way. Registered nurse (RN)-A had been identified as the charge nurse for main level was noted to be in resident room 109 at the time of the initial observation and was responsible for the keys. During constant observation four night shift nursing assistants and a housekeeping staff was noted in the area. At 5:45 a.m. (Seven minutes after keys were noted to be in med room door lock) RN-A returned to the nurse station. During interview RN-A stated, "I guess anyone could get in there." RN-A reported the keys were to be locked in the west wing medication cart when not in use. Observation of the medication storage room revealed an unlocked refrigerator which	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. In accordance with State and Federal 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 meeting April 29, 30 and May 1, 2014, the licensed nurses and trained medication assistants were reminded to lock the medication room door whenever it is unattended or authorized staff are not in the immediate area observing access to the medication room. To monitor compliance, the Director of Nursing/designee will check the security of the medication room five times per week for two weeks. If noncompliance is	

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F 431	Continued From page 20 contained multiple syringes filled with lorazepam gel (medication to treat anxiety) 0.5 mg (milligram.) An emergency kit was noted to be on the counter. The kit was secured with a plastic tag that required scissors to open. The emergency medication kit list indicated the kit included 12 syringes of morphine (narcotic pain medication) 10 mg solution, two 10 mg morphine suppositories, one morphine 10 mg/milliliters (ml) injectable, six morphine immediate release tablets 15 mg, two Demerol (narcotic pain medication) 50 mg/ml injectable, six tablets norco (opioid pain medication) 5/325 mg, six tablets Tylenol #3, six tablets Percocet 5/325, and 6 tablets oxycodone 5 mg. On 4/9/14, at 10:35 a.m. the director of nursing (DON) reported the keys are to be locked in the medication cart. DON verified the keys in the door allowed any staff person to access the medications that had been stored. Staff access to medication storage policy requested but not provided. During the tour of the medication storage rooms it was observed that the main floor medication refrigerator and the emergency kit (eKit) that contained narcotics were not double locked. The narcotics were stored under a single secure lock only and are to be stored in separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and controlled medications are reconciled accurately. On 4/9/14 at 9:46 a.m. during the main floor medication storage tour with RN-B, it was observed that the medication refrigerator and the	F 431	noted, additional monitoring and staff education will be done. Compliance will be reviewed during the June quarterly Quality Assessment and Assurance Committee meeting.	

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F 431	Continued From page 21 eKit were not secured by a lock. The refrigerator contained lorazepam gel 0.5 mg (at least 20 made up in a syringe). The eKit had a plastic tag on it, and it was sitting on the countertop and not secured. The eKit per the emergency medication kit list contained morphine 20 mg/mi 0.5 ml (10 mg) syringe solution, morphine 10 mg suppository, norco 5/325 mg , Tylenol #3, percocet 5/325, morphine 10 mg/ml injectable, morphine IR 15 mg, Meperidine (Demerol) 50 mg/ml injectable and oxycodone 5 mg. On 4/9/14 at 12:30 p.m. during a second tour of the main floor medication storage room with the licensed practical nurse (LPN)-A it was noted that the eKit tag had been removed. LPN-A stated they had taken a medication out of the emergency kit for a resident. A policy titled Medication Storage of Medications in Facility undated provided by the Director of Nursing (DON), indicated that Schedule II medications are to be stored in a separate area under double lock.	F 431		
F 441 SS=F	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;	F 441		5/20/14

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F 441	Continued From page 22 (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 interview and document review, the facility failed to develop and implement an infection control surveillance program that included analysis and trending of surveillance data that included employee illness and this had the potential to affect all 74 residents in the facility. Findings include: The facility failed to maintain a functioning	F 441	Stewartville Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development 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	

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F 441	Continued From page 23 infection control program (ICP) which at a minimum needs to include the necessary components to track, trend and analyze employee illness and infections to determine infection cross contamination between the residents and staff. The facility was unable to provide documentation that they had tracked and trended employee illness. During an interview on 4/8/14 at 2:42 p.m. the director of nursing (DON) verified the facility did not have a system in place to track and trend employee illness. The Stewartville Care Center undated Infection Control policy was reviewed and did not address tracking and trending of employee illness.	F 441	infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures consistent with the current state and federal infection control regulations. The policies address the surveillance and investigation of infections and maintenance of accurate and comprehensive records of resident infections. The policies have been updated to include procedures for gathering data on employee infections. A registered nurse is assigned the responsibility to oversee the review and implementation of the policies and procedures. During the April 29, 30 and May 1, 2014 mandatory meetings, the licensed nurses were instructed on the new policies for obtaining information on employee infections and completion of the employee infection data gathering form. The infection control nurse will review and organize the data to facilitate tracking and trending of resident and employee illnesses/ infections. Compliance with facility policies and regulatory requirements will be monitored by the Director of Nurses/designee through review of the infection control related forms, logs and spreadsheets. The results of the infection control surveillance and investigation activities are reviewed monthly as part of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING ______ B. WING ______	04/10/2014

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F 441	Continued From page 24	F 441	continuous quality improvement program. Compliance will be reviewed at the June quarterly Quality Assessment and Assurance Committee meeting and ongoing.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___________	**04/08/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Stewartville Care Center was found 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. 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 85 beds and had a census of 75 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2014

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 The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		