Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2026

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

RE: CCN: 245349
Cycle Start Date: April 7, 2026

Dear Administrator:

On April 7, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 8, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 8, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 8, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new

admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 8, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Stewartville Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 8, 2026. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

An equal opportunity employer.

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April 23, 2026

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

Re: Event ID: 22D091-H1

Dear Administrator:

The above facility survey was completed on April 7, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stewartville Care Center	**120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/6/26 through 4/7/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H53497282C(2662156). The following complaint was reviewed. H53491040C(2970212), with a deficiency issued at F600 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/01/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0600	Regulation 483.12 Freedom from Abuse, Neglect, and Exploitation Tag F600 Disclaimer Statement This Plan of Correction is submitted as required by regulation. The facility respectfully disagrees with the findings as written in the Statement of Deficiencies and does not concede that a deficient practice exists. However, this plan is submitted to demonstrate the facility’s ongoing commitment to resident safety, regulatory compliance, and continuous quality improvement.	05/01/2026

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

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

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F0600 SS = G	Continued from page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to protect a resident's right to be free from verbal abuse for 1 of 3 residents (R4) when R1 who had a history of cognitive impairment, personality changes, impulsiveness, and making poor choices, repeatedly yelled at R4, made a threat to shoot him in the head, and entered his room on three different occasions. Findings include: R4's admission minimum data set (MDS) dated 1/15/26, he was cognitively intact, no depression or behaviors. He was occasionally incontinent with bowel movements and frequently incontinent with urination. His care areas triggered activities of daily living, urinary incontinence, falls, and pressure ulcers. R4's care plan dated 1/15/26, indicated he had polyneuropathy (nerves to the arms and legs are damaged causing numbness, tingling, pain, and weakness), repeated falls, heart issues, pain in the right hip and knees, weakness, and lower back pain. He needed assistance with the toilet, bathing, grooming, and dressing. R4's progress notes by LPN-A dated 3/26/26 at 4:19 p.m., indicated she was alerted to an incident that happened in R4's room. She found R4 "visibly shaken and choked up" stating R4 did not feel safe and wanted to change rooms. R1 came very close to R4's face and was waving his fingers acting like he was going to hit him. R1 threatened to shoot R4. R1 and R4 shared a bathroom. R4 indicated he always made sure R1's bathroom was unlocked when he finished toileting because he feared what R1 would do. R4's progress notes by RN-A dated 3/27/26 at 10:33 a.m., indicated R4's family came to the facility to discuss the incident that happened with R1. They were concerned R1 would come back to the facility,	F0600	Continued from page 1 The facility takes the safety of all residents seriously and the facility has policies and procedures in place to protect and prevent all residents from all forms of abuse and neglect. Prior to the situation being investigated during the survey, R1 and R4 had only arguments or disagreements that per the SOM did not rise to the need to be reported. Per the State Operations Manual (SOM) Resident-to-resident altercations that must be reported in accordance with the regulations include any willful action that results in physical injury, mental anguish, or pain, as defined at §483.5. The table below includes examples of resident-to-resident altercations and whether they are required to be reported. NOTE: This is not an exhaustive list of all reportable types of resident-to-resident altercations. There may be other incidents that are also reportable. Examples of Mental/Verbal Conflict Required to Report Not Required to Report (Unless it rises to the level of what's described in the first column) • Intimidation • Bullying- Aggressive behavior in which someone intentionally* and repeatedly causes another resident mental anguish or discomfort** (adapted from the American Psychological Association 9F2 • Communication that is motivated by an actual or perceived characteristic, such as race, color, religion, sex, disability, or sexual orientation that results in mental anguish or social withdrawal** • Threats of violence • Inappropriate sexual comments that are used in a deliberately* threatening manner Inappropriate sexual comments that offend, humiliate, or demean a resident**; • Taking and/or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging	05/01/2026

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F0600 SS = G	Continued from page 2 and the behavior would continue. R4 stated he did not want to share a bathroom or be located close to R1 if he returned. R1's hospital summary dated 1/21/26, indicated he was in a motor vehicle accident in 1974, where he was thrown through the windshield and suffered a basilar skull fracture and coma. The incident left him with personality changes and mild cognitive impairment. On 1/21/26, he was admitted to the hospital related to progressive weakness, falls, and an inability to care for himself. His mental status at that time included memory and attention deficit, impulsiveness, made poor choices leading to an inability to care for himself. In addition, he was severely malnourished. R1's admission Minimum Data Set (MDS) dated 1/28/26, indicated he had moderate cognitive impairment, minimal depression, and no behaviors during the seven days look back period. He triggered cognition abilities, inability to complete activities of daily living, urinary incontinence, falls, nutrition, and pressure ulcers. R1's care plan dated 2/6/26 indicated he needed limited assistance from staff to set up clothing, and help dress as needed, personal care, and shower. He was continent of bowel and bladder, and independent with toileting. R1's progress notes by LPN-B dated 2/16/26 at 10:42 a.m., indicated R1 was yelling about R4's commode stating it should not be left in the room. He brought the commode to the shower room and told staff to "keep the damn thing out of his room." R1's progress notes by LPN-B dated 2/17/26 at 9:38 a.m., indicated R1 removed R4's commode from his room yelling "He do not care! He knows the laws." R1 pushed the commode all the way to the shower room, slamming it into the wall. R1's progress notes by LPN-B dated 2/17/26 at 1:22 p.m., indicated R1 was frustrated with R4's commode (portable toilet placed over the facility toilet to function as a riser) and the shared bathroom situation. She informed him he was not allowed to go into other residence rooms and remove items.	F0600	Continued from page 2 • Non-targeted outbursts • Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations • Arguments or disagreements, which do not include any behavior or communication identified in the "Required to Report" column Corrective Action for Residents Affected The facility conducted a thorough review of the identified incident involving the resident(s) referenced in the survey. R1 was immediately removed from the situation and then from the facility. R1 was transferred to the Emergency Department for an evaluation and did not return to the facility, instead being discharged to the community from the Emergency Department. An immediate assessment of R4 was completed to ensure safety, well-being, and absence of injury. Although initially upset by the situation, R4 did not express ongoing fear or mental anguish at the time of the situation. Appropriate notifications were made per facility policy and Minnesota reporting requirements, including to the resident(s) representative(s) and applicable state agencies, if indicated. The facility completed a Vulnerable Adult Report following further conversations with R4 as required by regulation because R4 later exhibited ongoing concerns related to the reported situation. The facility felt this expression was because R4 family continued to speak of the situation to R4. R4 did not display any ongoing mental anguish or social withdrawal and was functioning as baseline until the situation was brought up by others. Interventions were reviewed and updated in the	05/01/2026

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F0600 SS = G	Continued from page 3 R1's provider note dated 3/20/26, indicated he suffered from depression, anxiety, impatience, and angry outburst since 1974. He was unable to live independently at home and manage his needs. Hospital weight was 107 lbs. and upon admission to the facility it increased to 118 lbs. R1's progress notes by LPN-A dated 3/26/26 at 4:42 p.m., indicated R1 was angry and told her he was frustrated when the bathroom door was locked when he needed to use it. He described the incident with R4 when he was unable to use the bathroom because the door was locked. He was angry when he went into R4's room, and he pointed his finger at R4's face and he told him "I will shoot you in the face if this happens again." Staff observed R1 leave the room only to return and continue to threaten R4. Staff were concerned that he would physically harm R4 based on his threats and behavior. This was not the first time, and R1 was capable of hurting R4. The police were contacted. R1's progress notes by LPN-A dated 3/26/26 at 5:11 p.m., indicated R1 was transported to the hospital for evaluation. R1's hospital emergency encounter note dated 3/26/26, indicated R1 was brought to the facility for aggressive behavior towards another resident. He told them he was upset with the shared bathroom door being locked all the time and this had been occurring at least six times in the past two weeks. He was frustrated with the staff's lack of action. R1's progress notes by RN-B dated 3/26/26 at 10:22 p.m., indicated the hospital wanted to discharge R1 back to the facility. She told the hospital they were unable to accommodate his return because they had not been able to ensure the other patient would be safe and needed time to address the safety concerns. The facility administrator's investigation statement dated 3/26/26, indicated while she was talking with R4, R1 was standing in the hallway watching them. She tried to redirect R1 several times, but he refused to leave. R4 was visibly shaken up and stated R1 pointed his finger at him and said he was going to shoot him in the head while he was sleeping. She then accompanied R1 to her office. R1 was very	F0600	Continued from page 3 resident's care plan as needed to reflect individualized safety measures and preferences. The facility policy and procedure for Abuse Identification, Intervention and Prevention was reviewed and felt to be appropriate. Staff followed the policy and responded to the situation promptly and correctly. The facility policy and procedure for resident-to-resident altercations was reviewed and felt to be appropriate. Staff followed the policy and responded to the situation promptly and correctly. No other residents in the facility were identified as being at risk during this situation with staff acting immediately and appropriately to ensure all residents were safe and secure from being involved or witness to the situation as it was taking place in the facility. Systemic Changes / Measures to Prevent Recurrence While the facility maintains that staff acted appropriately and within policy, the following steps have been implemented to reinforce expectations and prevent potential concerns: Re-education of all staff on: Abuse, neglect, and exploitation definitions per federal and Minnesota guidelines Mandatory reporting requirements and timelines Resident rights and dignity Appropriate staff-resident interactions Appropriate resident-resident interactions Review and reinforcement of the facility's Abuse Prevention Policy, including reporting protocols and investigative procedures	05/01/2026

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F0600 SS = G	Continued from page 4 agitated and the administrator worried about her own safety. She contacted the police to transport him along with EMS to the hospital. She stated they did not have the means to do one-to-one care or transfer him to another room in the facility. Initially he refused to go to the hospital but later agreed if he could go to his room and get something. They followed him to his room and found him yelling and punching things. Police report dated 3/27/26 at 8:02 a.m., indicated they responded to the 911 call at the facility to investigate the incident. The police officer spoke with R4 who stated he had encounters with R1 six or seven times prior regarding the shared bathroom door being locked. Staff indicated they did not have an open room for R1 to be transferred to, and they did not have the staff to provide continuous observation to make sure R4 would be safe. R1's progress notes by social worker (SW)-A dated 3/27/26 at 2:17 p.m., indicated she hoped R1 could return to the facility. She did talk with him about his behavior but at that time he was still unwilling to take responsibility for his actions. She added based on his medical history regarding the traumatic brain injury (TBI) he had a lack of impulse control, and it did not take much to make him angry. R4's progress notes by Administrator dated 3/30/26 at 9:28 a.m., indicated R4's family wanted to know if R1 would be returning to the facility. It was explained to them that he was not. They were concerned that he could still come back and harm their father and what the facility would do to prevent him from coming back. R4 became agitated during the conversation, and it was decided that they would no longer talk about the incident in front of the resident to prevent further agitation. R4's progress notes by Administrator dated 4/3/26 at 9:44 a.m., indicated R4 had returned to his baseline and did not mention the incident to staff while doing cares. During an interview on 4/6/26 at 10:00 a.m., family member (FM)-A stated R1 suffered from a traumatic brain injury 53 years ago. Since he became a loner and did not participate in any family activities. He stopped talking to her three years ago when she was trying to get him to follow up with doctor	F0600	Continued from page 4 Leadership review of current practices to ensure clarity and consistency in expectations Enhancement of communication processes to ensure timely follow up of concerns. Enhancement of timely response and interventions to resident-to-resident situations that may not initially require reporting to prevent escalation. Monitoring / Quality Assurance The facility's Quality Assurance and Performance Improvement (QAPI) Committee will review: All allegations of abuse or neglect Incident/accident trends Compliance with reporting requirements Audits will be completed for any resident-to-resident altercations to ensure compliance to the steps for deescalation and prevention for the next six (6) months. Audits will be conducted ongoing by the QAPI Team: for any Vulnerable Adult Reports submitted. Any identified concerns will be addressed promptly with re-education and/or corrective action as needed and warranted. Staff will receive the reeducation on or before May 1, 2026. Staff who do not work prior to that date or those on leave will receive the education prior to their next shift or upon their return to work. Responsible Party Administrator / Director of Nursing / Designee	05/01/2026

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Stewartville Care Center	**120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976**

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F0600 SS = G	Continued from page 5 appointments. When he finally contacted her, she went to see him and found him in bad shape. He lost a lot of weight and told her all he wanted to do was lay in bed and die. She had spoken with him after the incident, and he did not take responsibility for his actions. During an interview on 4/6/26 at 2:30 p.m. the administrator stated R4's family was very upset about the incident that occurred and the possibility that R1 would be returning to the facility. Previously R1 had been upset because he shared a bathroom with R4 who required the assistance of a commode over the toilet to raise the seat high enough for him to be able to use it. R1 did not like the commode in the bathroom and voiced his concerns. In addition, he complained about the bathroom door was always locked when he needed to use it. When the subject first occurred, staff were reminded to make sure they unlocked that door before they left the bathroom. Then they removed the commode completely out of the bathroom when he was done using it. When R1 walked by his room and saw that he had a commode in his room he started to yell, and he took the commode out of his room twice. In response the staff covered the commode with a sheet. They also placed a sign on the bathroom door reminding staff to make sure they unlock the bathroom door when R4 was done. She added after the incident they did not accept R1 back to the facility because they did not have enough staff conduct constant supervision. In addition, they did not have a room with a private bath available. When the event occurred staff immediately separated both residents along with shutting all residence stores and the fire door to keep other staff out of the area. R4's family was very upset and threatened to remove their father from the facility if R1 returned. They also wanted police charges placed on R1 and a legal restraining order. During an interview on 4/7/26 at 11:02 a.m., R4 stated during the incident he wanted to smack him but R1 looked so frail he was afraid of hurting him. He was afraid of R1 and had been telling the staff for over a month that the patient was "nuts". One time, R1 saw the commode in his room and dragged the chair out of the room down the hallway. He said if R1 returned to the facility he would move out. He wanted the nursing staff to call the police because he had made a death threat to him when he stated he wanted to shoot him in the head. At the time of the interview, he said he forgot about the incident and was okay to talk about it. He had been very	F0600	Continued from page 5 Completion Date All corrective actions will be completed by: May 1, 2026	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245349	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stewartville Care Center	**120 FOURTH STREET NORTHEAST , STEWARTVILLE, Minnesota, 55976**

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F0600 SS = G	Continued from page 6 concerned about the situation regarding the bathroom doors and always reminded the staff to unlock the door when they were done using it. During an interview on 4/7/26 at 1125 a.m., RN-C stated R1 had been upset about the bathroom door being locked when he needed to use it and later unhappy with the commode whether it was in the bathroom or in R4's room. At times he had been confrontational with staff and had difficulty redirecting him, the facility did not have a private room for him nor the ability to separate them. She said once R1 gained strength and mobility she was concerned about the residents' safety. During an interview on 4/7/26 at 12:00 p.m., R4 asked if R1 could come to the facility and harm him again. Explained to him several times the facility had discharged R1 from the facility, and R1 did not have the means to return to the facility. During an interview on 4/7/26 at 2:30 p.m., the administrator stated R1 Did not like sharing a bathroom with R4. Initially the problem revolved around the bathroom door continued to be locked when R1 was done with the toilet. R1 needed assistance from staff to toilet, and they placed a commode over the toilet to raise the seat. She stated R1 did not like the commode in the bathroom so after using it they returned it to R4's room. Later when R1 walked past his room and saw the commode he went inside and started yelling and removed the commode, bringing it to the shower room. In response to that incident staff made sure the commode was in the other patient's room and covered with a sheet but that did not stop him from going into the room again yelling at staff and bringing the commode back to the shower room. They placed a sign on the door to remind staff to unlock R1's bathroom door when they were done using it. On 3/26/26, when R1 became upset the door was locked, R4 was using the bathroom, and staff communicated with him they were almost finished. Staff were unable to deescalate the situation before R1 entered R4's room. During the incidents between R1 and R4 she looked to see if they could separate them into different rooms without sharing a bathroom, but they had no availability at the time. In addition, they did not have staff to sit with R1 continually. She added after every encounter between the two residents they addressed the situation, developed interventions, and updated the staff. None of the incidents prior ever became	F0600		05/01/2026

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F0600 SS = G	Continued from page 7 physical or threatening and no harm was done. Facility policy Abuse Prevention Plan dated 2/24/26, indicated Prevention included completing a vulnerable assessment upon admission, care plan identified risks, and monitoring the resident for worsening cognitive impairment, aggressive behavior, and communication deficit. Staff education included abuse prevention training at orientation and annually along with conflict resolution, and cultural awareness. Facility policy Abuse Prohibition & Zero-Tolerance Policy dated 2/24/26, indicated All residents have the right to be free from abuse from staff or other residents. All employees are mandatory reporters. The facility would complete an investigation and report abuse to state agencies. The facility prohibits retaliation against reporters. The administrator was responsible for enforcement of the policy to include reporting, investigating, and prevention.	F0600		05/01/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 through 4/7/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H53491040C(2970212), H53497282C(2662156). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		05/01/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		05/01/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 26, 2026

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

RE: CCN: 245349
Cycle Start Date: April 7, 2026

Dear Administrator:

On April 23, 2026, we notified you a remedy was imposed.

On May 13, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 1, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 8, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 23, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 8, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 1, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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