Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 9, 2025

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

RE: CCN: 245349
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 30, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

HZahler

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

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

RE: CCN: 245349
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING ______ B. WING ______	C 12/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/10/24, 12/11/24, 12/12/24, 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: H53492305C (MN00108900) with a deficiency cited at F656. 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.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		12/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 12/26/2024

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

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F 657	Continued From page 1 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the comprehensive care plan for diabetic management that included goals and individualized interventions for 2 of 3 residents (R1, R2) reviewed for diabetic management. Findings incude: R1's face sheet identified R1 had diagnoses that included type 1 diabetes mellitus (autoimmune disease where the pancreas fails to produce insulin) with hyperglycemia (high blood sugar), unspecified diabetic retinopathy (diabetic complication that leads to vision loss) without macular degeneration, other diabetes complications unspecified, hypoglycemia (low blood sugar) without coma. R1's quarterly minimum data set (MDS) dated 9/26/24, identified R1 had verbal behaviors directed at others that occurred 1 to 3 days, did	F 657	Stewartville Care Center's interdisciplinary team develops comprehensive care plans for all residents. These care plans include information about each resident's individual care needs based on information gathered from assessments, medical providers, the resident, if possible, family members or other responsible resident representatives and other facility staff involved in the care of the residents. These care plans are reviewed and revised following each assessment or as needed for changes in resident conditions. Providing care for residents living with diabetes is a part of Stewartville Care Center's person-centered care environment which supports a high quality of life while managing this and other medical diagnosis and conditions. The	

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F 657	Continued From page 2 not reject cares, and had insulin injections daily. R1's lab report dated 4/9/24, identified a hemoglobin A1C (blood test that measures the average amount of sugar in the blood for over the past few months) result was 8.6 which indicated "high" with a reference range to be 4.0-5.6. R1's care plan dated 4/12/24, identified R1 is medication-diet controlled diabetic and receives insulin every day. R1's goal was to have stabilization of diabetes as evidenced by all blood sugars below 150. Review at each physician visit and care conference. Interventions included: administer medications as ordered, provide labs as ordered, staff to do chemstrips as ordered and report any changes to physician, staff to monitor food intake and remind R1 of diabetic diet. R1's physician orders included orders for insulin and included the order dated 5/17/24, that directed R1 to have blood sugar checks before every meal and at hour of sleep (HS) via Dexcom monitor (continuous glucose monitoring device). Review of R1's care plan did not address a communication plan between R1 and staff for the Dexcom smart phone application installed on R1's personal cell phone that would log the blood sugars and alert R1 when blood sugars were too low or too high. Further did not specify a goal range for R1's blood sugars. R1's medication administration record (MAR) for November 2024, identified blood sugar checks via Dexcom monitor were scheduled at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. Record review identified R1 had a wide range blood sugars; being as low as 47 and as high as 600.	F 657	facility provides an interdisciplinary approach to care and services that focuses holistically on the needs of the residents. Qualified staff have the competencies and skills to support residents through the implementation of individualized approaches to care that are directed toward understanding and/or accommodating a resident's lifestyle and the changes required while living with a diagnosis of diabetes. These may include dietary modifications, oral medication management and insulin administration as well as monitoring blood glucose levels. The staff ensures that the person-centered care and services reflect the resident's goals, while maximizing the resident's independence, choices, and safety. In order to ensure that residents individualized diabetic care needs are met, at the time of admission the facility staff assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. Resources are provided as necessary for the residents to be successful in reaching their achievable goals. The resident's plan of care is reviewed at least quarterly and whenever there is a change in the resident's condition that impacts safety and functional status or other abilities. The staff is aware that residents living with diabetes require specialized services and supports, (e.g., diet/nutrition, skin care,	

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F 657

Continued From page 3

Although the MAR identified blood sugars as low as 47 and as high as 600, and R1 had documented refusals to take his prescribed insulin, R1's care plan did not address R1's symptomology of hypo/hyperglycemia nor individualized interventions to prevent/mitigate the risk of hypo/hyperglycemia and management of. Additionally the care plan did address behavioral management of R1's rejections of insulin medication to control blood sugars.

During an interview on 12/10/24 at 3:41 p.m., licensed practical nurse (LPN)-A stated she would use her nursing judgement for low blood sugar and get something to eat/drink and hold insulin until resident would reach a healthy number. For hyperglycemia LPN-A would give insulin and recheck the blood sugar later barring the resident was asymptomatic. LPN-A stated R1 was very difficult to manage his blood sugars.

R2's face sheet identified R2 had diagnoses of type 2 diabetes with diabetic chronic kidney disease, hyperglycemia.

R2's quarterly MDS dated 11/20/24, identified R2 was poor at making decisions, and needed cues/supervision. R2 had insulin injections daily.

R2's lab report dated 11/7/24, identified A1C of 8.2, which indicated "high" with a note from the medical provider that stated over the past 3 months the hemoglobin has greatly improved and to continue with current orders for blood sugar control.

R2's physician orders included insulin and an order dated 9/26/24, identified blood sugar four times a day. R2 had a Dexcom sensor. Notify

F 657

medication/insulin administration, education and monitoring) that vary, based on each individual's challenges related to their condition and disease characteristics.

Resident #1 is no longer a resident at the facility, so this care plan was not further reviewed or revised. The areas reported as lacking to meet all diabetic needs during the survey were used as guidance for review of other diabetic resident care plans and staff education.

Resident #2 care plan was reviewed and revised to include directives for nursing staff on resident's blood glucose goals, management of the Dexcom sensor and interventions for episodes of hypo/hyperglycemia.

The care plans of all other residents with a diagnosis of diabetes were reviewed and revised, if needed to ensure they contain diabetic management goals and focuses including identification and treatment of hypo/hyperglycemia.

The facility has created a Diabetic Protocol Binder that will be kept at the Nursing Desk. This binder contains a clinical protocol for diabetes management and procedural guidance for insulin management, management of hypoglycemia, nursing care of the resident with diabetes mellitus and obtaining a fingerstick glucose level. All licensed nursing staff will be educated on this binder.

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F 657	Continued From page 4 provider if blood sugar <70 or >550 via note or if outside parameters and symptomatic notify provider same day. R2's MAR dated November 2024, identified blood sugar checks via Dexcom monitor were scheduled at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. Record review identified R2 had blood sugars above 200 very frequently R2's care plan did not include diabetic management focus that included R2's blood sugar range goals, management of the Dexcom sensor, R2's symptomology of hypo/hyperglycemia nor individualized interventions to prevent/mitigate the risk of hypo/hyperglycemia and management of. During and observation and interview on 12/12/24 at 8:14 a.m., registered nurse (RN)-A went to R2's room and went to the receiver and pushed the button that lit the screen up and read 205 as the blood sugar. RN-A verified that R2 did not have diabetic management in the care plan. During an interview on 12/11/24 at 1:06 p.m., Director of Nursing (DON) reviewed the care plan of R1 and that it did not address diabetic management clearly. Reviewed R2's care plan and verified that the care plan did not address diabetic management. DON would expect the care plans to have diabetic management in them, and moving forward they definitely will. During an interview on 12/12/24 at 2:26 p.m., Administrator stated the facility wanted the standard things to watch for hyper and hypoglycemic issues, watch their feet, wounds that are not healing, should be everyone with	F 657	The facility policy for Comprehensive Care Plans was reviewed and updated on December 26, 2024, to include a focus on establishment of measurable goals/objectives and desired outcomes. To ensure that all resident care plans are designed to meet the individual goals of each resident, the facility is completing a review of each resident care plan. This will be completed for each new admission and for each current resident during their next scheduled assessment period and care conference. This process will be ongoing for all residents and will be the responsibility of the Director of Nursing or designee with support from the MDS Coordinator and others who complete sections of the MDS Assessment and Care Area Triggers. For further compliance assurance, the Facility Administrator will complete a review of the care plan for new admissions following the initial assessment to ensure appropriate person-centered care planning has been completed. This will be ongoing for the next five admissions to the facility. To prevent a recurrence of this issue and to ensure all licensed nursing staff members are aware of the plan, all licensed nursing staff members will receive education on the Diabetic Protocol Binder, the revised policy and the new plan for review and revision of care plans as well as basic care plan information.	

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F 657	Continued From page 5 diabetes. Each care plan should be individualized. Administrator would expect the care plan to be updated and have each residents diabetic issues addressed within it. The facility Comprehensive Care Plan policy and procedure revised 8/18, identified the care plan as a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals including how they can best be accomplished, types of care and consultation needed, what methods are most successful, modification to ensure best results.	F 657	Other staff members who complete MDS Assessments, CAA's and Care Planning were provided with information on care planning only. Licensed Nursing Staff have also been assigned a course on Diabetes in the facility's education platform. This was assigned on December 16,2024 and is due to be completed no later than January 10, 2025. Other mentioned education will begin on December 26, 2024, and will continue until all appropriate staff have received the education.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: YWGO11

Dear Administrator:

The above facility was surveyed on December 10, 2024 through December 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: ______ B. WING ______	C 12/12/2024

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2 000	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 12/10/24, 12/11/24, 12/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: ______ B. WING ______	C 12/12/2024

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) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the d12/12/24ate when they will be completed. The following complaints were reviewed: H53492305C and MN00108900 with a licensing order issued at 0565. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the comprehensive care plan for diabetic management that included goals and individualized interventions for 2 of 3 residents (R1, R2) reviewed for diabetic management. Findings incude: R1's face sheet identified R1 had diagnoses that included type 1 diabetes mellitus (autoimmune disease where the pancreas fails to produce insulin) with hyperglycemia (high blood sugar), unspecified diabetic retinopathy (diabetic complication that leads to vision loss) without macular degeneration, other diabetes complications unspecified, hypoglycemia (low blood sugar) without coma.	2 565	Acknowledged and corrected	12/26/24

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2 565	Continued From page 3	2 565		

R1's quarterly minimum data set (MDS) dated 9/26/24, identified R1 had verbal behaviors directed at others that occurred 1 to 3 days, did not reject cares, and had insulin injections daily.

R1's lab report dated 4/9/24, identified a hemoglobin A1C (blood test that measures the average amount of sugar in the blood for over the past few months) result was 8.6 which indicated "high" with a reference range to be 4.0-5.6.

R1's care plan dated 4/12/24, identified R1 is medication-diet controlled diabetic and receives insulin every day. R1's goal was to have stabilization of diabetes as evidenced by all blood sugars below 150. Review at each physician visit and care conference. Interventions included: administer medications as ordered, provide labs as ordered, staff to do chemstrips as ordered and report any changes to physician, staff to monitor food intake and remind R1 of diabetic diet.

R1's physician orders included orders for insulin and included the order dated 5/17/24, that directed R1 to have blood sugar checks before every meal and at hour of sleep (HS) via Dexcom monitor (continuous glucose monitoring device).

Review of R1's care plan did not address a communication plan between R1 and staff for the Dexcom smart phone application installed on R1's personal cell phone that would log the blood sugars and alert R1 when blood sugars were too low or too high. Further did not specify a goal range for R1's blood sugars.

R1's medication administration record (MAR) for November 2024, identified blood sugar checks via Dexcom monitor were scheduled at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. Record

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2 565	Continued From page 4	2 565		

review identified R1 had a wide range blood sugars; being as low as 47 and as high as 600. Although the MAR identified blood sugars as low as 47 and as high as 600, and R1 had documented refusals to take his prescribed insulin, R1's care plan did not address R1's symptomology of hypo/hyperglycemia nor individualized interventions to prevent/mitigate the risk of hypo/hyperglycemia and management of. Additionally the care plan did address behavioral management of R1's rejections of insulin medication to control blood sugars.

During an interview on 12/10/24 at 3:41 p.m., licensed practical nurse (LPN)-A stated she would use her nursing judgement for low blood sugar and get something to eat/drink and hold insulin until resident would reach a healthy number. For hyperglycemia LPN-A would give insulin and recheck the blood sugar later barring the resident was asymptomatic. LPN-A stated R1 was very difficult to manage his blood sugars.

R2's face sheet identified R2 had diagnoses of type 2 diabetes with diabetic chronic kidney disease, hyperglycemia.

R2's quarterly MDS dated 11/20/24, identified R2 was poor at making decisions, and needed cues/supervision. R2 had insulin injections daily.

R2's lab report dated 11/7/24, identified A1C of 8.2, which indicated "high" with a note from the medical provider that stated over the past 3 months the hemoglobin has greatly improved and to continue with current orders for blood sugar control.

R2's physician orders included insulin and an order dated 9/26/24, identified blood sugar four

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2 565	Continued From page 5	2 565		

times a day. R2 had a Dexcom sensor. Notify provider if blood sugar <70 or >550 via note or if outside parameters and symptomatic notify provider same day.

R2's MAR dated November 2024, identified blood sugar checks via Dexcom monitor were scheduled at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. Record review identified R2 had blood sugars above 200 very frequently

R2's care plan did not include diabetic management focus that included R2's blood sugar range goals, management of the Dexcom sensor, R2's symptomology of hypo/hyperglycemia nor individualized interventions to prevent/mitigate the risk of hypo/hyperglycemia and management of.

During and observation and interview on 12/12/24 at 8:14 a.m., registered nurse (RN)-A went to R2's room and went to the receiver and pushed the button that lit the screen up and read 205 as the blood sugar. RN-A verified that R2 did not have diabetic management in the care plan.

During an interview on 12/11/24 at 1:06 p.m., Director of Nursing (DON) reviewed the care plan of R1 and that it did not address diabetic management clearly. Reviewed R2's care plan and verified that the care plan did not address diabetic management. DON would expect the care plans to have diabetic management in them, and moving forward they definitely will.

During an interview on 12/12/24 at 2:26 p.m., Administrator stated the facility wanted the standard things to watch for hyper and hypoglycemic issues, watch their feet, wounds that are not healing, should be everyone with

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2 565	Continued From page 6	2 565		

diabetes. Each care plan should be individualized. Administrator would expect the care plan to be updated and have each residents diabetic issues addressed within it.

The facility Comprehensive Care Plan policy and procedure revised 8/18, identified the care plan as a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals including how they can best be accomplished, types of care and consultation needed, what methods are most successful, modification to ensure best results.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.