DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 29, 2020

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

RE: CCN: 245349
Survey Start Date: February 28, 2020

Dear Administrator:

On July 27, 2020 the Minnesota Department(s) 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 July 6, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
March 13, 2020

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

RE: CCN: 245349
Cycle Start Date: February 28, 2020

Dear Administrator:

On February 28, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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 May 28, 2020 (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 August 28, 2020 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

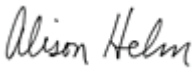
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 02/28/2020

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 2/27/20 and 2/28/20 an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint(s) was/were found to be substantiated: H5349034C with no deficiency H5349035C with no deficiency H5349036C with deficiency at F610 . The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		4/6/20

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

Electronically Signed | 03/19/2020

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 610	Continued From page 1 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review facility failed to ensure measures were put in place to reduce verbal abuse and ensure such allegations were fully investigated and documented for 1 of 1 residents (R4) being reviewed for reported staff to resident abuse. Findings include: R4's face sheet and diagnosis list included major depression, legally blind and suffering end stage kidney disease. R4's annual Minimum Data Set (MDS) assessment dated 1/15/20, indicated R4 required limited assistance of one person with most activities of daily living (ADLs). R4 was assessed as cognitively intact with no significant behavioral symptoms. A report to the state agency (SA) on 2/1/20, R4 had complained to another resident R5, that a trained medication aid (TMA)-A had told her to "shut up and lay down" on the evening of 1/30/20.	F 610	In response to any allegations of resident abuse, neglect, exploitation, or mistreatment, Stewartville Care Center has policies and procedures which require that all alleged incidents are thoroughly investigated. The policies and procedures addressing the investigation of abuse/neglect allegations were reviewed and found appropriate. The policies have measures to prevent further potential abuse, neglect, exploitation, and mistreatment while the investigation is in progress. The policies instruct staff to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. The abuse/neglect investigation is comprehensive and includes 1) interviews	

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F 610	Continued From page 2 According to an interview on 2/27/20, at 4:56 p.m. the facility social worker (SW) stated she was responsible to report any vulnerable adult (VA) concerns to the state agency and to interview staff, residents and family or report to families. SW said she did not keep separate files, but wrote all the information she gathered into the five day report to the state agency and indicated the five day report was the end date of the investigation. SW reported she had not received any written grievances related to concerns from residents about how they were treated by staff and said they would discuss any concerns about staffing at Resident Council meetings. SW said she did not sit on any committee where further investigation into any type of VA report might be reviewed. According to the five day report dated 2/6/20, the facility interviewed R4, TMA-A, R5 and two nursing assistants who had been working 1/30/20. The report also indicated TMA-A was removed from the duties of passing medication to R4 until the investigation was complete, but failed to indicate she was reassigned to nonresident care duties or to avoid areas of the building R4 frequents. According to an interview 2/27/20, 5:56 p.m. TMA-A stated she felt like R4 did not like her because of an interaction between the two of them quite some time before. TMA-A said a previous social worker (SW) in the facility had told her that R4 had made a complaint that TMA-A had not helped her when she had requested. TMA-A stated she thought it was important to encourage residents to be as	F 610	with all persons who can provide information beneficial to the investigative process 2) maintaining a record of who is interviewed, the date of the interview, the interviewee□s involvement in the incident, and notes summarizing the content of the interview 3) assessing the resident for injury and monitoring as indicated after allegations of abuse, neglect or rough handling 4) providing documentation verifying that the resident was kept safe during the investigation with increased monitoring afterward if indicated and 5) to relieve any staff member alleged to be involved in an abuse/neglect investigation of direct resident cares and any non staff member of unsupervised visits until the investigation is complete. The nursing staff will be reeducated on the vulnerable adult investigation policies and procedures during small group and one-to-one meetings. (In consideration of precautions related to the spread of COVID-19, an all staff meeting will not be scheduled.) Being sensitive to residents□ stress levels, the residents□ perception of staff actions, and effective interventions to manage difficult behaviors will be addressed. The staff will be reminded of the reference notebooks at each nursing station containing the policies and procedures addressing Stewartville Care Center Vulnerable Adult Awareness and Prevention. TMA-A has been counseled on effective communication techniques with residents exhibiting behaviors that may have a negative impact on others.	

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F 610	Continued From page 3 independent as possible and said, in that instance, she had asked R4 to wash her own face which was what had caused the problem. TMA-A denied having any problems with other residents, but said she felt she had continued problems with R4 because she did not respond to R4's behaviors in the same manner other staff did. TMA-A stated other staff "played" into her behaviors. TMA-A gave the example of R4 throwing her teddy bear on the floor when upset and scolding Teddy for his behavior. She said other staff would pick up the toy and talk to it as though it was real, but TMA-A said she would not do that. TMA-A said if a person had dementia she would not try to change their thoughts if they believed a toy was real, but she knew where R4 "was at cognitively" and so would not do that with her. On the evening of 1/30/20, TMA-A stated R4 was upset and had been yelling a lot. She said R4 had not been using her call light when she needed assistance, she had simply been yelling. TMA-A stated R4 will often have an evening like that, yelling a lot and throwing Teddy on the floor. On that evening, TMA-A said she went into R4's room and told her she should use her call light so they could be sure she needed assistance and was not simply yelling at Teddy. She also said she had explained that staff would not know what was going on if they heard yelling and they were in another room assisting someone else. TMA-A stated she had several days off from work after the evening of 1/30/20 and when she returned to work she said she was told by the nurses to no longer have any interactions with R4, and said that's what she had done. She stated she no longer passed medications to R4 and although she would see her in the dining room, she would not even take her meal request.	F 610	During the routine interdisciplinary team meeting with department supervisors March 17, 2020, the administrator will review the policies and procedures for interviewing staff, residents and others involved in a vulnerable adult investigation. The need to remove any person against whom an allegation of abuse, neglect or financial exploitation from resident care responsibilities and resident care areas will be addressed. The Vulnerable Adult Reporting Committee consisting of the Administrator, Social Worker, Director of Nursing and other supervisory staff as appropriate will continue to meet to review the circumstances surrounding allegations of abuse, neglect and financial exploitation. Incident reporting and investigative results are routinely reviewed; necessary follow up is discussed. The investigation of the reported accusations of verbal abuse for resident number 4 was reviewed by the interdisciplinary team and administrative staff as part of the facility□s ongoing quality assurance and performance improvement process. Any future investigation of alleged abuse or neglect for resident number 4 and all other residents will 1) include comprehensive interviews with all persons who could provide information helpful to the investigation 2) comply with the facility□s	

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F 610	Continued From page 4 According to an interview 2/27/19, 6:30 p.m. a licensed practical nurse (LPN)-A stated she was aware that TMA-A and R4 had "conflicting personalities." LPN-A stated she had not been working the evening of 1/30/20, but was aware since that time that TMA-A should no longer work with R4. She stated R4 might still see TMA-A as sometimes she did have to work on her hallway, but the nurses were to give R4's medications. She stated she was not aware of TMA-A having any problems with any other residents and generally would work on the hall opposite R4's. According to an interview 2/28/19, 12:41 p.m. R5 stated she was a friend of R4 and felt as though she needed to "watch over" her because she was not "really capable of doing that herself." She confirmed that she had reported the incident between TMA-A and R4 based on what she had heard from R4. She stated she had not personally witnessed the incident and said she had never had any problems with TMA-A but it was important to report. According to an interview 2/28/20, 12:46 p.m. R4 stated TMA-A was responsible for passing medication on her hallway the evening of 1/30/20. R4 stated she was not feeling her best that evening, she was worried about an upcoming surgery on her eyes, had recently received some sad news about some family problem, and had some recent issues with her dialysis treatment. She stated she felt like there were a lot of things going on in the hall that evening, and reported, it seemed to her, that the staff were "just running around and hollering" in the hallways. R4 confirmed she believed TMA-A	F 610	investigative policies and procedures including removing any staff person against whom an allegation of maltreatment has been made from resident care responsibilities and resident care areas and 3) include adequate documentation of verifying compliance with the related policies and procedures. Compliance will be monitored by the Administrator/designee by tracking vulnerable adult reports for three months to ensure that appropriate documentation of interviews and other investigative policies and procedures were followed. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed at the quarterly May 2020 Quality Assurance and Performance Improvement Committee meeting.	

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F 610	Continued From page 5 yelled at her to "be quiet" on the evening of 1/30/20 but that she, R4, just needed a little extra care that evening because it had been a hard day. She said she had had problems on and off with TMA-A in the past. She also said she was not afraid of TMA-A, but she was mad. R4 confirmed TMA-A no longer worked with her. According to an interview 2/28/19, 1:26 pm the interim director of nursing (IDON) confirmed that she had received a call from SW upon receiving notification that R5 had reported concerns about TMA-A's verbal response to R4. She stated it was quite late in the evening but they made a decision that TMA-A would no longer be allowed to work with R4. She was unable to confirm that TMA-A had been removed from working with other residents during the investigation. She stated they had not taken this step because there had not been previous complaints about TMA-A by other residents. IDON was unable to confirm if they had interviewed any other residents to see if they had any concerns about TMA-A and their safety. IDON stated they had developed a team to investigate incidents in the facility such as accidents or falls, but VA concerns, such as allegations of abuse, were not discussed at those committee meetings. IDON stated the SW was not part of the committee to investigate facility incidents such as falls, but she was responsible to interview staff, resident or family as applicable. IDON stated she was not aware that the written facility action in the five day report indicated she was to provide education on resident rights to TMA-A as well to other staff. IDON confirmed that she did meet with TMA-A and had a discussion related not working with R4. IDON also said she had previously held a nursing meeting where she	F 610		

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F 610	Continued From page 6 talked about resident rights; however, she had not met with the nursing assistants or held an all staff meeting since the incident. A request was made to review TMA-A's personnel record. The file did not contain evidence that TMA-A had received any specific training in relation to the incident with R4 on 1/30/20, nor did the file contain any evidence that she had received counseling by a previous SW in response to a previous incident with R4 related to cares. Facility policy titled Stewartville care Center Preventing Resident Abuse dated 2/2017 read, "preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment." According to the procedure: in the event of suspected maltreatment, the needs of the resident will be immediately assessed and the safety of the resident will be ensured. The safety and health of the resident(s) will be attended to before any other action is taken. Immediate steps should be taken to ensure that no resident remains in danger of maltreatment. Facility provided an additional document titled Stewartville Care Center Reporting/Investigating Resident Accidents Incidents dated 2/2017. The document indicated all accidents/incidents involving residents will be thoroughly investigated by management and findings of such investigation will be kept on file by the Director of Nursing. The facility provided a document titled Stewartville Care Center Abuse and/or Neglect Investigation dated 2/2017. The document indicated the investigation must include interview with person reporting incident, any witnesses, the resident,	F 610		

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F 610	Continued From page 7 staff members on all shifts having contact with the resident during the time of the alleged incident, family members, and visitors; as well as ensuring an interview of other residents in which the employee provides are or service for. The document indicated an employee accused of resident abuse would be reassigned to nonresident care duties or put on leave until the results of the investigation had been reviewed. A policy titled Stewartville Care Center Protection of Residents During Abuse Investigation dated 2/2017, employees accused of abuse would be reassigned to nonresident care duties or put on leave. The document also indicated the employee should not be in any part of the building with the resident frequents during the investigation period.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2020

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

Re: Event ID: QMYI11

Dear Administrator:

The above facility survey was completed on February 28, 2020 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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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	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 2/27/20 through 2/28/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to investigate the following complaints: The following complaint were found to be	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 02/28/2020

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2 000	Continued From page 1 substantiated: H5349034C H5349035C H5349036C No correction orders were issued. 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.	2 000		