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	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stewartville Care Center	120 Fourth Street Northeast Stewartville, MN 55976

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview and document review the facility failed to report an unwitnessed fall with injury to the state agency (SA) for 1 of 2 residents (R1) reviewed for falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had dementia, anxiety and depression with severely cognitive deficits, used a wheelchair and walker, frequently incontinent of bladder and occasional incontinent of bowel. R1's care plan dated 2/20/23, indicated R1 had delusional disorders, neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function) and was at risk for falls due to history of falls, poor decision making and dementia and was on antipsychotic medication. Staff were directed to initiate fall prevention program to include using call light for assistance, bed low and locked, per occupational therapy and physical therapy; all transfers & ambulation-SBA (stand by assist) with four wheeled walker, due to cognitive decline & poor safety with increased fall risk. In addition, call light always with in reach, position as need for safety at nursing station am, pm and at night and motion sensor alarm. Review of R1's Progress Note: -6/04/24 at 6:20 a.m., R1 was found on floor in front of her bedroom. Fall was unwitnessed and resulted in a large hematoma above the left eye and upper lip. Resident kept on the floor in the upper seated position. Lying caused greater discomfort. At 7:00 a.m. Gold Cross (Emergency Medical Transport) arrived and left with resident, daughter was notified and will meet resident at St Mary's Emergency Department (ED). A follow up note indicated at 7:41 p.m. by the director of nursing (DON), received call from ED, R1 was admitted with diagnosis (Dx) of rib fx (fracture) and UTI (urinary tract infection). ED Provider Notes dated 6/04/24 at 3:04 p.m., indicated R1 was a [AGE] year-old female with a history of dementia from nursing home coming to the ED after a fall. She has two anterior rib fractures and right-sided chest wall pain. She also has contusion to her left eye and face. The prior team was worried of her having delirium, with altered mental status alternating between somnolence (sleepy) and agitation. Sources of delirium could be pain, in the setting of fall and rib fractures, or a urinary tract infection. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/24 at 10:55 a.m., NA-E stated she found R1 on the floor on 6/04/24, when she had her recent fall. NA-E stated she had her [NAME] stocking (compression stockings) on which should have been taken off when she went to bed, and her motion sensor alarm was not going off. NA-E stated she heard R1 yelling for help and when she got in the room R1 had blood coming down her face so she yelled for the nurse to come help. During interview on 6/12/24 at 11:25 a.m., NA-D stated she checks the alarms when she starts her shift in the morning to make sure they are on. NA-D indicated she was on the North Hall the morning R1 fell and never heard an alarm sound which she added she had mentioned to the DON, social worker, and the nurses. During interview on 6/11/24 at 10:54 a.m., with the director of nursing (DON) stated the fall R1 had was not reported to the state agency since she felt the care plan was followed, the sensor alarm was in R1's room and felt the staff were following it and her bed was low and in the locked position. The DON added she did not know why the motion sensor alarm did not go off the morning of R1's fall. Vulnerable Adult Procedure revised 11/17/20, indicated all cases of known or suspected maltreatment of vulnerable adults to the MN Department of Health Office Of health facility complaints. If the incident involving the vulnerable adult requires immediate emergency services to protect the individual, call MAARC.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and document review the facility failed to thoroughly investigate an unwitnessed fall with a serious injury for 1 of 2 residents (R1) whose motion sensory alarm did not sound/alert staff of movement and R1 fell . This resulted in rib fractures and contusions to R1's face. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had dementia, anxiety and depression with severely cognitive deficits, used a wheelchair and walker, frequently incontinent of bladder and occasional incontinent of bowel. R1's care plan dated 2/20/23, indicated R1 had delusional disorders, neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function) and was at risk for falls due to history of falls, poor decision making and dementia and was on antipsychotic medication. Staff were directed to initiate fall prevention program to include using call light for assistance, bed low and locked, per occupational therapy and physical therapy; all transfers & ambulation-SBA (stand by assist) with four wheeled walker, due to cognitive decline & poor safety with increased fall risk. In addition, call light always with in reach, position as need for safety at nursing station am, pm and at night and motion sensor alarm. Review of R1's Progress Note: -6/04/24 at 6:20 a.m., R1 was found on floor in front of her bedroom. Fall was unwitnessed and resulted in a large hematoma above the left eye and upper lip. Resident kept on the floor in the upper seated position. Lying caused greater discomfort. At 7:00 a.m. Gold Cross (Emergency Medical Transport) arrived and left with resident, daughter was notified and will meet resident at St Mary's Emergency Department (ED). A follow up note indicated at 7:41 p.m. by the director of nursing (DON), received call from ED, R1 was admitted with diagnosis (Dx) of rib fx (fracture) and UTI (urinary tract infection). ED Provider Notes dated 6/04/24 at 3:04 p.m., indicated R1 was a [AGE] year-old female with a history of dementia from nursing home coming to the ED after a fall. She has two anterior rib fractures and right-sided chest wall pain. She also has contusion to her left eye and face. The prior team was worried of her having delirium, with altered mental status alternating between somnolence (sleepy) and agitation. Sources of delirium could be pain, in the setting of fall and rib fractures, or a urinary tract infection. During interview on 6/12/24 at 10:55 a.m., NA-E stated she found R1 on the floor on 6/04/24, when she had her recent fall. NA-E stated she had her [NAME] stocking (compression stockings) on which should have been taken off when she went to bed, and her motion sensor alarm was not going off. NA-E stated she heard R1 yelling for help and when she got in the room R1 had blood coming down her face so she yelled for the nurse to come help. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/12/24 at 11:25 a.m., NA-D stated she checks the alarms when she starts her shift in the morning to make sure they are on. NA-D indicated she was on the North Hall the morning R1 fell and never heard an alarm sound which she added she had mentioned to the DON, social worker, and the nurses. During interview on 6/11/24 at 10:54 a.m., with the director of nursing (DON) stated the fall R1 had was not reported to the state agency since she felt the care plan was followed, the sensor alarm was in R1's room and felt the staff were following it and her bed was low and in the locked position. The DON added she did not know why the motion sensor alarm did not go off the morning of R1's fall. The DON also indicated she was planning to have a nursing meeting today to go over the falls policy and to make sure they are completing the forms. Lastly, the DON stated she added a new alarm to R1's bed which was a pressure sensor alarm, which would alarm in R1's room. This was additional the motion sensory alarm. Vulnerable Adult Procedure revised 11/17/20, indicated an internal investigation will be started by the staff making the initial report along with with social services and licensed nurses. Staff initiating internal investigation should collect written statements from all staff members involved in incident. if there are any staff involved in the incident or abuse, they should be removed from the floor pending completion of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview and document review, the facility failed to implement care planned fall interventions for 1 of 2 residents (R1) reviewed for accidents. This resulted in actual harm for R1 who had an unwitnessed fall while self-transferring when the motion sensor alarm did not sound and failed to alert staff that R1 was self-transferring as intended per care plan. Additionally, the facility failed to determine why the motion sensor alarm did not alert staff following the fall and added a second alarm. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had dementia, anxiety, and depression with severe cognitive deficits. R1 used a wheelchair and walker, was frequently incontinent of bladder and occasional incontinent of bowel. R1's care plan dated 2/20/23, indicated R1 had delusional disorders, neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and was at risk for falls due to history of falls, poor decision making and dementia and was on antipsychotic medication. Staff were directed to initiate fall prevention program to include using call light for assistance, bed low and locked, per occupational therapy and physical therapy; all transfers & ambulation-SBA (stand by assist) with four wheeled walker, due to cognitive decline and poor safety with increased fall risk. Additionally, call light always within reach, position as needed for safety at nursing station am, pm and night shift. The care plan also indicated a motion sensor alarm (that sounds at the nurse's station making staff aware that R1 was self-transferring). R1's nursing assistant care sheet (which directs care staff for cares) indicated R1 used assist of one with walker for am and pm cares, used reading glasses, and was incontinent of bowel and bladder. (The care sheet did not indicate R1 was at risk for falls nor that an alarm system was in place to notify staff R1 was attempting to get out of bed). Review of Observation Detail List Report for R1 revealed a Fall Risk (Acuity) completed on 5/2/24, indicated R1 was disorientated, had poor visual impairment, and had a fall risk score of 20 (10 or higher represented a high risk for falls). Review of R1's Falls indicated the following: -11/09/23 R1 fell at 9:56 a.m. while trying to pull back curtain to talk to roommate and bumped head. Intervention included: educated R1 to use call light and wait for staff to assist. -12/19/13 at 4:443 p.m., R1 found on floor unwitnessed fall, trying to get up, staff heard R1 yelling. Intervention included: Reminders to use call light, bed low and locked, restorative therapy, motion sensor alarm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-12/22/23 at 4:01 p.m. R1 fell attempting to reach for walker from bed (to self-transfer) to use the bathroom, unwitnessed fall. Intervention included: Reminder to use call light for assistance, bed low and locked, restorative therapy, and motion sensor alarm. -12/31/23 at 5:38 p.m. R1 was found on floor next to roommates' bed with wheelchair next to her. R1 bumped head. Intervention included: Reminders to use call light for assistance, bed low and locked, restorative therapy, motion sensor alarm, position as needed for safety at nursing station a.m., p.m. and night. -6/04/24 at 6:20 a.m. (progress note indicated) R1 was found on floor in front of her bedroom. Fall was unwitnessed and resulted in a large hematoma above the left eye and upper lip. Resident kept on the floor in the upper seated position. Lying caused greater discomfort. At 7:00 a.m. Gold Cross (Emergency Medical Transport) arrived and left with resident, daughter was notified and will meet resident at St Mary's Emergency Department (ED). A follow up note indicated at 7:41 p.m. by the director of nursing (DON), received call from ED, R1 was admitted with diagnosis (Dx) of rib fx (fracture) and UTI (urinary tract infection). ED Provider Notes dated 6/04/24 at 3:04 p.m., indicated R1 was a [AGE] year-old female with a history of dementia from nursing home coming to the ED after a fall. She has two anterior rib fractures and right-sided chest wall pain. She also has contusion to her left eye and face. The prior team was worried of her having delirium, with altered mental status alternating between somnolence (sleepy) and agitation. Sources of delirium could be pain, in the setting of fall and rib fractures, or a urinary tract infection. During interview on 6/10/24 at 6:20 p.m., family member (FM)-A stated R1 has Lewy's bodies dementia, and she forgets she can no longer walk anymore. FM-A stated the staff informed her R1 was found on 6/04/24 in front of the doorway on the floor and there was blood on her nightstand, which was odd because she had a window bed. FM-A stated her window bed was at least 10 feet from the doorway. In addition, she was told there was no alarm sounding which was concerning to her since R1 has had several falls and she was wondering why they would not be using the alarm when it was working to reduce her falls. During interview on 6/11/24 at 9:30 a.m., registered nurse (RN)-A stated R1 was found sitting on the floor in front of the door the morning of 6/04/24, and there was no sensor alarm sounding. R1 was bleeding on her upper lip and leg and RN-A could see she was rubbing it all over. RN-A indicated the overnight staff are supposed to make sure the alarms were working and are on so we are alerted if she was up, the fall occurred at the beginning of her shift, R1 was still in her pajamas and had no shoes on. RN-A stated due to the emergency and because she was in so much pain, they did not change her or move her before the paramedics arrived. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During observation and interview on 6/11/24 at 10:36 a.m., R1 was sitting with nursing assistant (NA)-A with motion sensor receiver next to NA-A. NA-A stated she was not working the day R1 fell . NA-A stated R1 used to have a motion sensor alarm but thinks they stopped it a while back and does not know why, but now she has a new pressure sensor alarm on her bed. During observation, R1 was looking at a bird magazine and commented at how beautiful the hummingbirds were. R1 had some bruising noted from the top of the left side of her face down to her chin, bruising was noted to be dark purple in color. Across the hall, the housekeeper made a noise with her mop bucket (moderate noise you would expect when mopping) and R1 was observed to get startled by the noise (jumped) and stated, I had one of those, but it never made noise like that! During observation on 6/11/24 at 10:40 a.m., R1's room had a motion sensor alarm on the dresser facing her bed (which would alarm to the nurse's station), along with a pressure sensor bed alarm (which would alarm in R1's room) attached to her bedside rail. NAR-A pushed R1's bed to demonstrate how the alarm sounded on bed. During interview on 6/11/24 at 10:54 a.m., with the director of nursing (DON) stated the fall R1 had was not reported to the state agency since she felt the care plan was followed, the sensor alarm was in R1's room and felt the staff were following it and her bed was low and in the locked position. The DON added she did not know why the motion sensor alarm did not go off the morning of R1's fall. The DON also indicated she was planning to have a nursing meeting today to go over the falls policy and to make sure they are completing the forms. Lastly, the DON stated she added a new alarm to R1's bed which was a pressure sensor alarm, which would alarm in R1's room. This was additional the motion sensory alarm. During interview on 6/11/24 at 3:24 p.m., LPN-B indicated she didn't hear the alarm go off the morning of R1's fall, we heard her yell. LPN-B stated she knows there were batteries in the motion sensor because she checks that all the time, adding the motion alarm assist staff to know when R1 was getting up so we can keep her from falling. During interview on 6/12/24 at 10:41 a.m., nursing assistant (NA)-C stated R1 has a motion alarm in her room, and that was the only alarm she had. In addition, we keep her bed in the low position due to her falls history and that keeps her from being able to get up. NA-C also indicated R1 can be easily startled. Adding, if R1 was in the hallway eating a snack, and someone spoke to her she would jump up or if you knocked on the door to her room, you would startle her. During interview on 6/12/24 at 10:55 a.m., NA-E stated she found R1 on the floor on 6/04/24, when she had her recent fall. NA-E stated she had her [NAME] stocking (compression stockings) on which should have been taken off when she went to bed, and her motion sensor alarm was not going off. NA-E stated she heard R1 yelling for help and when she got in the room R1 had blood coming down her face so she yelled for the nurse to come help. During interview on 6/12/24 at 11:25 a.m., NA-D stated she checks the alarms when she starts her shift in the morning to make sure they are on. NA-D indicated she was on the North Hall the morning R1 fell and never heard an alarm sound which she added she had mentioned to the DON, social worker, and the nurses. NA-D also stated she mentioned that R1 should be closer to the nurse's station since she was a fall risk but was told there was no open beds. Additionally, when speaking directly about the new intervention of the pressure sensor alarm, NA-D stated R1 can easily be startled, even when you speak to her, or you knock on her door. Startling her can also make her more likely to fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 6/12/24 at 11:40 a.m., with assistant director of nursing (ADON) stated he is on the falls committee and helped with interventions. ADON added, R1 had a motion sensor alarm and no other alarms. Lastly, R1 was to be reminded to use her call light and ask for assistance with transfers and the bed has is to be in a low and locked position (the bed has to be low so the wheels go up so they don't move). The facility failed to determine why the motion sensor alarm failed, which had assisted to reduce falls since December 2023. Instead, the facility added a second pressure sensor alarm, without assessing the potential disruption this sounding alarm may cause the resident (with a diagnosis of Lewy bodies) and failed to update care planning/direct care staff sheets and nursing staff to the fall prevention and changes for R1 to prevent future falls. Falls Prevention and Management revised 3/03/2023, indicated to ensure residents live in an environment that is free from hazards over which the facility has control, and provide appropriate intervention to each resident to prevent avoidable accidents and injuries.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview and document review, the facility failed to assess, develop and implement a person centered dementia care treatment plan for 1 of 2 residents (R1) reviewed who had Lewy body dementia, was startled easily, at risk for falls, and the facility added a pressure sensor alarm to R1's bed, which sounded in her room. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had dementia, anxiety and depression with severely cognitive deficits, used a wheelchair and walker, frequently incontinent of bladder and occasional incontinent of bowel and had no falls since admission. R1's care plan dated 2/20/23, indicated R1 had delusional disorders, neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function) and was at risk for falls due to history of falls, poor decision making and dementia and was on antipsychotic medication. Staff were directed to initiate fall prevention program to include using call light for assistance, bed low and locked, per occupational therapy and physical therapy all transfers & ambulation-SBA (stand by assist) with four wheeled walker, due to cognitive decline & poor safety with increased fall risk. In addition, call light always with in reach, position as needed for safety at nursing station am, pm and at night shift, and motion sensor alarm. R1's Falls Observation dated 5/02/24, indicated R1 was disorientated had poor visual impairment and had a fall risk score of 20 (10 or higher represented a high risk for falls). During observation and interview on 6/11/24 at 10:36 a.m., R1 was sitting with nursing assistant (NA)-A with motion sensor receiver next to NA-A. NA-A stated she was not working the day R1 fell . NA-A stated R1 used to have a motion sensor alarm but thinks they stopped it a while back and does not know why, but now she has a new pressure sensor alarm on her bed. During observation, R1 was looking at a bird magazine and commented at how beautiful the hummingbirds were. Across the hall, the housekeeper made a noise with her mop bucket (moderate noise you would expect when mopping) and R1 was observed to get startled by the noise (jumped) and stated, I had one of those, but it never made noise like that! During interview on 6/12/24 at 10:41 a.m., nursing assistant (NA)-C stated R1 has a motion alarm in her room, and that was the only alarm she had. In addition, we keep her bed in the low position due to her falls history and that keeps her from being able to get up. NA-C also indicated R1 can be easily startled. Adding, if R1 was in the hallway eating a snack, and someone spoke to her she would jump up or if you knocked on the door to her room, you would startle her. During interview on 6/12/24 at 11:25 a.m., when speaking directly about the new intervention of the pressure sensor alarm, NA-D stated R1 can easily be startled, even when you speak to her, or you knock on her door. NA-D added, startling her can also make her more likely to fall. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/11/24 at 10:54 a.m., the director of nursing (DON) stated she added a new alarm to R1's bed which was a pressure sensor alarm which would alarm in R1's room. This was additional to the motion sensor alarm. The facility was unable to provide evidence of an assessment process that determined a sounding pressure alarm was a person centered intervention to reduce falls for R1 based on her diagnosis and response environment/sounds around her, potentially putting her a greater risk of falls.