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

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and document review, the facility failed to protect a resident's right to be free from verbal abuse for 1 of 3 residents (R4) when R1 who had a history of cognitive impairment, personality changes, impulsiveness, and making poor choices, repeatedly yelled at R4, made a threat to shoot him in the head, and entered his room on three different occasions.Findings include: R4's admission minimum data set (MDS) dated [DATE], he was cognitively intact, no depression or behaviors. He was occasionally incontinent with bowel movements and frequently incontinent with urination. His care areas triggered activities of daily living, urinary incontinence, falls, and pressure ulcers. R4's care plan dated 1/15/26, indicated he had polyneuropathy (nerves to the arms and legs are damaged causing numbness, tingling, pain, and weakness), repeated falls, heart issues, pain in the right hip and knees, weakness, and lower back pain. He needed assistance with the toilet, bathing, grooming, and dressing. R4's progress notes by LPN-A dated 3/26/26 at 4:19 p.m., indicated she was alerted to an incident that happened in R4's room. She found R4 visibly shaken and choked up stating R4 did not feel safe and wanted to change rooms. R1 came very close to R4's face and was waving his fingers acting like he was going to hit him. R1 threatened to shoot R4. R1 and R4 shared a bathroom. R4 indicated he always made sure R1's bathroom was unlocked when he finished toileting because he feared what R1 would do. R4's progress notes by RN-A dated 3/27/26 at 10:33 a.m., indicated R4's family came to the facility to discuss the incident that happened with R1. They were concerned R1 would come back to the facility, and the behavior would continue. R4 stated he did not want to share a bathroom or be located close to R1 if he returned. R1's hospital summary dated 1/21/26, indicated he was in a motor vehicle accident in 1974, where he was thrown through the windshield and suffered a basilar skull fracture and coma. The incident left him with personality changes and mild cognitive impairment. On 1/21/26, he was admitted to the hospital related to progressive weakness, falls, and an inability to care for himself. His mental status at that time included memory and attention deficit, impulsiveness, made poor choices leading to an inability to care for himself. In addition, he was severely malnourished. R1's admission Minimum Data Set (MDS) dated [DATE], indicated he had moderate cognitive impairment, minimal depression, and no behaviors during the seven days look back period. He triggered cognition abilities, inability to complete activities of daily living, urinary incontinence, falls, nutrition, and pressure ulcers. R1's care plan dated 2/6/26 indicated he needed limited assistance from staff to set up clothing, and help dress as needed, personal care, and shower. He was continent of bowel and bladder, and independent with toileting. R1's progress notes by LPN-B dated 2/16/26 at 10:42 a.m., indicated R1 was yelling about R4's commode stating it should not be left in the room. He brought the commode to the shower room and told staff to keep the damn thing out of his room. R1's progress notes by LPN-B dated 2/17/26 at 9:38 a.m., indicated R1 removed R4's commode from his room yelling He do not care! He knows the laws. R1 pushed the commode all the way to the shower room, slamming it into the wall. R1's progress notes by LPN-B dated 2/17/26 at 1:22 p.m., indicated R1 was frustrated with R4's commode (portable toilet placed over the facility toilet to function as a riser) and the shared bathroom situation. She (continued on next page)

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.

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

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

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	informed him he was not allowed to go into other residence rooms and remove items. R1's provider note dated 3/20/26, indicated he suffered from depression, anxiety, impatience, and angry outburst since 1974. He was unable to live independently at home and manage his needs. Hospital weight was 107 lbs. and upon admission to the facility it increased to 118 lbs. R1's progress notes by LPN-A dated 3/26/26 at 4:42 p.m., indicated R1 was angry and told her he was frustrated when the bathroom door was locked when he needed to use it. He described the incident with R4 when he was unable to use the bathroom because the door was locked. He was angry when he went into R4's room, and he pointed his finger at R4's face and he told him I will shoot you in the face if this happens again. Staff observed R1 leave the room only to return and continue to threaten R4. Staff were concerned that he would physically harm R4 based on his threats and behavior. This was not the first time, and R1 was capable of hurting R4. The police were contacted. R1's progress notes by LPN-A dated 3/26/26 at 5:11 p.m., indicated R1 was transported to the hospital for evaluation. R1's hospital emergency encounter note dated 3/26/26, indicated R1 was brought to the facility for aggressive behavior towards another resident. He told them he was upset with the shared bathroom door being locked all the time and this had been occurring at least six times in the past two weeks. He was frustrated with the staff's lack of action. R1's progress notes by RN-B dated 3/26/26 at 10:22 p.m., indicated the hospital wanted to discharge R1 back to the facility. She told the hospital they were unable to accommodate his return because they had not been able to ensure the other patient would be safe and needed time to address the safety concerns. The facility administrator's investigation statement dated 3/26/26, indicated while she was talking with R4, R1 was standing in the hallway watching them. She tried to redirect R1 several times, but he refused to leave. R4 was visibly shaken up and stated R1 pointed his finger at him and said he was going to shoot him in the head while he was sleeping. She then accompanied R1 to her office. R1 was very agitated and the administrator worried about her own safety. She contacted the police to transport him along with EMS to the hospital. She stated they did not have the means to do one-to-one care or transfer him to another room in the facility. Initially he refused to go to the hospital but later agreed if he could go to his room and get something. They followed him to his room and found him yelling and punching things. Police report dated 3/27/26 at 8:02 a.m., indicated they responded to the 911 call at the facility to investigate the incident. The police officer spoke with R4 who stated he had encounters with R1 six or seven times prior regarding the shared bathroom door being locked. Staff indicated they did not have an open room for R1 to be transferred to, and they did not have the staff to provide continuous observation to make sure R4 would be safe. R1's progress notes by social worker (SW)-A dated 3/27/26 at 2:17 p.m., indicated she hoped R1 could return to the facility. She did talk with him about his behavior but at that time he was still unwilling to take responsibility for his actions. She added based on his medical history regarding the traumatic brain injury (TBI) he had a lack of impulse control, and it did not take much to make him angry. R4's progress notes by Administrator dated 3/30/26 at 9:28 a.m., indicated R4's family wanted to know if R1 would be returning to the facility. It was explained to them that he was not. They were concerned that he could still come back and harm their father and what the facility would do to prevent him from coming back. R4 became agitated during the conversation, and it was decided that they would no longer talk about the incident in front of the resident to prevent further agitation. R4's progress notes by Administrator dated 4/3/26 at 9:44 a.m., indicated R4 had returned to his baseline and did not mention the incident to staff while doing cares. During an interview on 4/6/26 at 10:00 a.m., family member (FM)-A stated R1 suffered from a traumatic brain injury 53 years ago. Since he became a loner and did not participate in any family activities. He stopped talking to her three years ago when she was trying to get him to follow up with doctor appointments. When he finally contacted her, she went to see him and found him in bad shape. He lost a lot of weight and told her all he wanted to do was lay in bed and die. She had spoken with him after the incident, and he did not take responsibility for his actions. During an interview on 4/6/26 at 2:30 p.m. the administrator stated R4's family was very upset about the incident that occurred and the (continued on next page)

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

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	possibility that R1 would be returning to the facility. Previously R1 had been upset because he shared a bathroom with R4 who required the assistance of a commode over the toilet to raise the seat high enough for him to be able to use it. R1 did not like the commode in the bathroom and voiced his concerns. In addition, he complained about the bathroom door was always locked when he needed to use it. When the subject first occurred, staff were reminded to make sure they unlocked that door before they left the bathroom. Then they removed the commode completely out of the bathroom when he was done using it. When R1 walked by his room and saw that he had a commode in his room he started to yell, and he took the commode out of his room twice. In response the staff covered the commode with a sheet. They also placed a sign on the bathroom door reminding staff to make sure they unlock the bathroom door when R4 was done. She added after the incident they did not accept R1 back to the facility because they did not have enough staff conduct constant supervision. In addition, they did not have a room with a private bath available. When the event occurred staff immediately separated both residents along with shutting all residence stores and the fire door to keep other staff out of the area. R4's family was very upset and threatened to remove their father from the facility if R1 returned. They also wanted police charges placed on R1 and a legal restraining order. During an interview on 4/7/26 at 11:02 a.m., R4 stated during the incident he wanted to smack him but R1 looked so frail he was afraid of hurting him. He was afraid of R1 and had been telling the staff for over a month that the patient was nuts. One time, R1 saw the commode in his room and dragged the chair out of the room down the hallway. He said if R1 returned to the facility he would move out. He wanted the nursing staff to call the police because he had made a death threat to him when he stated he wanted to shoot him in the head. At the time of the interview, he said he forgot about the incident and was okay to talk about it. He had been very concerned about the situation regarding the bathroom doors and always reminded the staff to unlock the door when they were done using it. During an interview on 4/7/26 at 1125 a.m., RN-C stated R1 had been upset about the bathroom door being locked when he needed to use it and later unhappy with the commode whether it was in the bathroom or in R4's room. At times he had been confrontational with staff and had difficulty redirecting him, the facility did not have a private room for him nor the ability to separate them. She said once R1 gained strength and mobility she was concerned about the residents' safety. During an interview on 4/7/26 at 12:00 p.m., R4 asked if R1 could come to the facility and harm him again. Explained to him several times the facility had discharged R1 from the facility, and R1 did not have the means to return to the facility. During an interview on 4/7/26 at 2:30 p.m., the administrator stated R1 Did not like sharing a bathroom with R4. Initially the problem revolved around the bathroom door continued to be locked when R1 was done with the toilet. R1 needed assistance from staff to toilet, and they placed a commode over the toilet to raise the seat. She stated R1 did not like the commode in the bathroom so after using it they returned it to R4's room. Later when R1 walked past his room and saw the commode he went inside and started yelling and removed the commode, bringing it to the shower room. In response to that incident staff made sure the commode was in the other patient's room and covered with a sheet but that did not stop him from going into the room again yelling at staff and bringing the commode back to the shower room. They placed a sign on the door to remind staff to unlock R1's bathroom door when they were done using it. On 3/26/26, when R1 became upset the door was locked, R4 was using the bathroom, and staff communicated with him they were almost finished. Staff were unable to deescalate the situation before R1 entered R4's room. During the incidents between R1 and R4 she looked to see if they could separate them into different rooms without sharing a bathroom, but they had no availability at the time. In addition, they did not have staff to sit with R1 continually. She added after every encounter between the two residents they addressed the situation, developed interventions, and updated the staff. None of the incidents prior ever became physical or threatening and no harm was done. Facility policy Abuse Prevention Plan dated 2/24/26, indicated Prevention included completing a vulnerable assessment upon admission, care plan identified risks, and monitoring the resident for worsening cognitive impairment, aggressive (continued on next page)

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

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	behavior, and communication deficit. Staff education included abuse prevention training at orientation and annually along with conflict resolution, and cultural awareness. Facility policy Abuse Prohibition & Zero-Tolerance Policy dated 2/24/26, indicated All residents have the right to be free from abuse from staff or other residents. All employees are mandatory reporters. The facility would complete an investigation and report abuse to state agencies. The facility prohibits retaliation against reporters. The administrator was responsible for enforcement of the policy to include reporting, investigating, and prevention.