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	06/18/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident assessment to self-administer medications, was implemented and followed consistently in accordance with physician orders for 1 on 1 resident (R8) reviewed for self-administration of medications.Findings include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living(ADL) and maximal assistance with mobility. R8's care plan dated 05/04/26 indicated, resident would like to administer oral medications and be more independent with ADL's. Resident was unable to self-administer safely medications, may self-administer inhalers/nebs after set up only. R8's active medications list review included an order for R8 to self-administer inhalers and nebulizer treatments only after set up by staff and could not self-administer oral medications safely dated 11/09/23. R8's self-administration of medication assessment dated [DATE] indicated, R8 did not wish to self-administer any medications, had moderately impaired cognitive status, made poor decision, required cues/supervision and based on evaluation, it was not appropriate for R8 to self-administer any medications. During an observation on 06/16/26 4:09 p.m., R8 was found sitting in a wheelchair in the room, holding in the left hand a 1 oz medication cup containing 4 tablets and in the right hand, an 8 oz clear cup, containing water. When asked who provided the medications and water, R8 stated, the medications were from a while ago and was unable to recall who provided the medications. At 4:38 p.m., R8 was found in the same position, with no medication cup in the left hand and the water cup was placed on the nightstand. When R8 was asked what happened to the medications, R8 was unable to recall. Further inspection showed the medication cup and the 4 tablets of medication on the floor and a small amount of spilled water. R8 ?s call light was used and trained medication aid (TMA)-A and registered nurse (RN)-A at 4:40 p.m responded to the call light. During an interview on 06/16/26 at 4:41 p.m., (TMA)-A stated, R8 was not supposed to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff and was unsure who provided the medications found on the floor. RN-A also confirmed, R8 was not to self-administer any oral medications except inhalers and nebulizer treatments only after set up by staff and would notify supervisor immediately. Medications found on the floor were identified as tramadol 50 mg tablet, 2 tablets of Tylenol 500mg and calcium citrate 200mg tablet. During an interview on 06/17/26 at 10:30 a.m., administrator indicated a near miss medication investigation report was completed and trained medication aid (TMA)-B was identified as staff member involved. During an interview on 6/17/26 at 1:43 p.m., TMA-B stated, they had provided R8 with an inhaler first, which R8 self-administered after set up, then the 4 tablets in a medication cup and water on 6/16/26 at 4:30 p.m., TMA-B confirmed was aware R8 was unable to self-administer oral medications except inhalers and nebulizer treatments only after set up by staff. TMA-B stated, was under the impression that R8 took the medications in her presence. During an interview on 06/18/2026 11:04 a.m., acting director of nursing (ADON), upon review of R8's self-administration of medication assessment dated [DATE] and confirmed, R8 was unable to self-administer any medications including inhalers and nebulizer treatments. Facility policy titled Self -Administration of Medication Policy revised on 6/16/26 indicated, nursing staff shall review self-administration (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation routinely and ensure appropriate entries are reflected on the Medication Administration Record (MAR).

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R27) reviewed for beneficiary notices.Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 had intact cognition. R27's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 2/15/26. R27's NOMNC form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 2/14/26. The form was signed by the resident dated 6/15/26. Additionally, R27's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 5/23/26. R27's NOMNC form dated 6/15/26, indicated R27's last covered day of Medicare Part A service was on 5/23/26. The form was signed by the resident dated 6/15/26. During an interview on 7/1/25 at 1:34 p.m., R27 stated she did not recall anyone reviewing the form mentioned above with her but was okay with her therapy services ending. During an interview on 6/17/26 at 9:28 a.m., administrator confirmed she oversaw reviewing NOMNCs with residents and, after reviewing R27's medical record, could not find evidence that the notice had been given to R27 at least two days before the end of Medicare Part A coverage as required. The facility's NOMNC policy dated 6/18/26 indicated the NOMNC must be delivered at least two calendar days before Medicare-covered services end.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 3 resident (R4, R1) reviewed for hospice care and smoking. Findings Include: R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was moderately cognitively impaired. R4's diagnosis included dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) with moderate agitation During record review on 6/16/26 at 10:01 a.m., noted R4 was admitted to hospice on 1/30/26. R4's comprehensive care plan failed to include a resident-specific hospice care plan, including hospice diagnosis, hospice provider information, and resident choices and preferences. During an interview on 6/16/26 at 1:24 p.m., registered nurse (RN)-A stated she is unsure why R4 was put on hospice, probably due to his infections or maybe his worsening dementia. RN-A stated she didn't know what end-of life preferences R4 had. During an interview on 6/16/26 at 1:27 p.m., Minimum Data Set (MDS)-A coordinator and RN-B stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident care plan and is updated to include pertinent hospice information. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. MDS-A confirmed R4 was admitted to hospice on 1/30/26. MDS-A confirmed R4's care plan did not have a hospice care plan. MDS-A and RN-B stated the hospice care plan is important, so all staff are aware of the resident status and how to care for him at the end-of-life stage. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan. R1 R1's quarterly Minimum Data Set (MDS) assessmen, dated 5/11/26, indicated intact cognition, and R1 was independent with mobility. R1's ecord review indicated R1's had impaired vision related to macular degeneration and was legally blind. R1 was able to ambulate up and down the halls in the facility and outside of the facility only in the area of the railing safely. Smoking observation/assessment dated [DATE] indicated, R1's was able to smoke independently, requested staff assistance when ready to go out to smoke and smoked less than a cigarette a day. R1's record review lacked smoking care plan (problem, goals/outcomes, and interventions). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/17/26 08:15 a.m., administrator acknowledged, R1 was able to smoke safely with staff assistance and had no smoking care plan in place. A facility policy titled Care Plans, Comprehensive Person-Centered dated 8/3/2018, the facility will provide a comprehensive person-centered interdisciplinary care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and document review, the facility failed to provide supervision to 1of 1 resident (R8) reviewed for activities of daily living who was left unattended on the toilet for more than 1 hour. Findings Include: R8's comprehensive Minimum Data Set (MDS) assessment, dated 5/11/26, identified R8 had impaired cognition and required extensive assistance with activities of daily living and maximal assistance with mobility. R8 ?s care plan dated 5/4/26 indicated, resident had a history of falling related to impulsiveness and perceived abilities. Motion sensor alarm to monitor movements due to unattended / unassisted transfers resulting in falls, reminders to use call light for all transfers. Record review indicated R8's had an unwitnessed fall on 6/12/26 at 10:06 a.m., in the bathroom, right beside the toilet and the wheelchair. R8's head was found leaning against the corner of the doorway. During an observation on 6/16/26 9:03 AM, R8 was assisted onto the toilet by nursing assistant (NA)-A. At 9:40 a.m., R8 was observed sitting on the toilet, chin to chest, sleeping and snoring lightly. At 10:10 a.m., staff returned to R8's bathroom and assisted R8 off the toilet, then to bed. During an interview on 6/16/26 2:21 p.m., nursing assistant (NA)-A stated, R8 was able to use the call light when ready, R8 had requested more time on the toilet when staff had gone too early in the past. When asked to clarify the meaning of too early, NA-A stated, 10 to 15 minutes. When pointed out to NA-A, R8 had fallen asleep on the toilet, NA-A stated, yes, R8 liked to sleep on the toilet. NA-A stated, today was busy or I would have gone back in there sooner. During an interview 6/18/26 11:04 a.m., assistant director of nursing (ADON) stated, the expectation was for staff to check in with residents at least 15 minutes when left unattended on the toilet. Facility policy titled Activity of Daily Living (ADL) Assistance and Functional Maintenance reviewed on 6/18/26 indicated, provide supervision and support to residents with balance deficit or fall risks.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to complete weekly wound assessment and documentation for 1 of 1 resident (R6) reviewed for pressure Ulcer/Injury who had 2 unhealed stage 4 pressure ulcers (full-thickness skin and tissue loss, exposed bone, ligament, cartilage, or muscle) on bilateral buttocks. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings Include:R6's quarterly Minimum Data Set (MDS) assessment, dated 6/3/26, identified R6 had intact cognition and was dependent on staff for activities of daily living and mobility. MDS identified two stage 4 pressure ulcers, pressure reducing device for bed, chair and application of nonsurgical dressing and ointment.R6's diagnoses included stage 4 pressure on right and left buttock, hereditary spastic paraplegia (inherited disorders that cause progressive stiffness and weakness in the legs, often leading to mobility challenges).R6's care plan dated 6/10/26, directed staff to assess the pressure ulcer location, stage, size (length, width and depth), presence/ absence of granulation (healing) tissues, conduct a systematic skin inspection weekly and report any signs of further skin breakdown.R 6's wound treatment order dated 4/14/26 included: dressing plan for the bilateral open stage 4 ischial pressure injuries, continue to use Vashe (wound cleanser) barely moistened kerlix covered with ABD (thick multi-layered medical dressing) pad held in place with silicone tape, 3 times daily.R6's Electronic Medical Record (EMR) review indicated R6 was hospitalized from [DATE] to 01/26/26 for progressive worsening of bilateral buttocks stage 4 pressure ulcers with concern for infection and a hospitalization from 05/14/26 to 5/18/26 for acute osteomyelitis (infection in a bone), both ischial (sit bones) wounds were open to bone and periosteum (connective tissues), with the left wound correlating with new osteomyelitis.Review of R6's EMR wound documentation identified 3 wound assessments and documentation in 90 days:On 3/31/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's. bottom looked good overall with scant amount of maceration to peri wound. Left buttock wound measured; 4 cm(centimeters) L(length) x 7 cm W(width)x 7 cm D (depth),Right gluteal wound measuring 2 cm (L) x 3.5 cm (W) x 5.3 cm (D).On 04/2/26, wound documentation indicated: old dressing was removed; area was cleansed with dermal wound cleanser; kerlix saturated in half solution of Dakin's.Left buttock wound measured; 9.6 cm (L) x 5.2 cm (W) x 9.2 cm (D),Right gluteal wound measuring 3.5 cm (L) x 2.7 cm (W) x 5.0 cm (D).On 6/3/26, wound documentation current indicated: wound care completed this AM after resident had a shower. Left buttock wound measured 1.5cm x 2.0 cmx 4.0cmRight buttock wound measured 2.0 cm x 4.0 cm x 6.4.cm, no s/s of infection, no odor, no drainage, resident denies pain and tolerated treatment well.During an observation and interview on 6/17/2026 7:22 a.m., R6 stated, wounds dressing changes were completed by 7 a.m., between 12 p.m., and 2:00 p.m., and after 7:00 p.m., R6 said he spent most of the day in the facility apartment visiting his wife and returned to the facility for medications and treatments.During observation on 6/17/2026 1:40 p.m. R6 returned to the facility, took scheduled medications, declined wound treatment and assessment, and returned to the facility apartment to visit his wife.During an interview on 06/17/26 12:50 p.m., licensed practical nurse, (LPN)-A stated, weekly wound assessment and documentation was completed by the nurse manager.During an interview on 06/17/26 10:57 a.m., interim director of nursing (IDON) stated, the expectation was all wounds would be measured and documented on weekly basis.During an interview on 06/17/26 at 2:33 p.m., licensed nurse practitioner (NP)-B expected facility staff to complete weekly wound assessment and report any issues identified.Facility policy title Skin Integrity, Wound, Care and Pressure Injury Prevention reviewed on 6/18/26 on indicated, all wound, and pressure injuries shall be assessed upon identification and monitored routinely thereafter. Assessment shall include Location, size and measurement, stage (if applicable), appearance of wound bed, drainage characteristics, sign and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms of infections, pain, periwound condition and response to treatment. Residents with existing wounds or pressure injuries shall have treatment goals and interventions reflected in the care plan.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R37) reviewed for pharmacy services. Findings include: R37 face sheet indicated R37 admitted to the facility on [DATE]. R37's admission Minimum Data Set (MDS) assessment, dated 6/9/26, indicated R37 was cognitively intact with no delirium and no behaviors. R37 had upper and lower body impairment and required assistance with all activities of daily living. The MDS also indicated R37 had diagnoses of anxiety and depression. R37's diagnoses list included heart disease, major depressive disorder, and generalized anxiety disorder. R37's care plan indicated R37 received an antianxiety medication related to anxiety disorder.R37's hospital discharge orders dated 6/3/26, indicated clonazepam (prescribed to treat anxiety)0.5 mg tablet give 1/2 tablet twice a dayR37's Medication Administration Record (MAR) indicated R37 had an order for clonazepam 0.5 mg tablet. Give 1/2 tablet twice a day scheduled. The MAR further indicated R37 did not receive the clonazepam from 6/3/26 evening shift through 6/15/26 due to drug not available. Additional notes on the MAR indicated on 6/3/26 drug unavailable, resident informed. Will call pharmacy in the AM. On 6/5/26 evening shift the MAR also indicated medication not found, also checked Ekit (emergency kit) not available. On 6/11/26 the MAR also indicated no written script from pharm(pharmacy).R37's progress notes indicated R37 was seen on 6/4/26 for a first post admission recertification with orders for labs placed. The progress notes also indicated R37 was seen at the facility by the nurse practitioner for an acute visit on 6/10/26. The progress notes lacked documentation a provider was updated of R37's clonazepam not being administered due to being unavailable. A hand written faxed document dated 6/4/26, to the medical director indicated FYI. [facility pharmacy] needs an updated script for [R37] clonazepam. Provider progress notes indicate the medical director was in the facility on 6/4/26 to sign R37's admission orders and R37 was seen for an acute visit on 6/10/26. Neither document mentioned needing a valid prescription for clonazepam. During an interview on 6/16/26 at 11:21 a.m., trained medication aide (TMA)-A stated if a medication was not found, she would look through all of the medication carts and call the pharmacy to order it. TMA-A stated staff are not supposed to document unavailable on the MAR. If a script is needed, she would tell the nurse on duty. When asked about R37's clonazepam, TMA-A stated I think they were trying to get her off of that, I'm not really sure. I know it wasn't a prior authorization thing. TMA-A looked through the medication cart and verified there was no card of clonazepam available. During an interview on 6/16/26 at 1:01 p.m., the pharmacy technician stated the pharmacy last filled 30 tablets of clonazepam for R37 on 11/6/25 and they do not have a current order for clonazepam for R37. During an interview on 6/16/26 at 1:08 p.m., licensed practical nurse (LPN)-A stated if a medication is not available the pharmacy is notified and a note is made in the progress notes. If the pharmacy states a new script is required, the provider is updated. LPN-A stated he does not work with R37 often but does recall one of the nurses stating messages were sent to the provider for the clonazepam order. LPN-A reviewed R37's progress notes and confirmed there is no documentation stating a provider was updated. LPN-A stated an SBAR (a note written to providers) is placed in the SBAR binder. LPN-A could not find documentation in the binder indicating a request for clonazepam was made. On 6/16/26 at 2:08 p.m., the administrator provided an SBAR that was written on 6/14/26 to the provider indicating discontinue orders for Clonazepam BID. No script, has not taken while here. During interview on 6/16/26 at 2:21 p.m., the nurse practitioner (NP) stated she is at the facility weekly. The NP confirmed R37 was discharged from the hospital with an order for clonazepam 0.5 mg tablet 1/2 tablet twice a day. The NP also confirmed R37 was seen by the medical director on 6/4/26 and by her on 6/10/26 for an acute visit. The NP stated she was unaware R37 had not been receiving clonazepam and did not see any documentation or fax indicating a request for a script for clonazepam. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NP stated she would expect to be notified immediately if a medication was unavailable. During an interview on 6/17/26 at 8:18 a.m., the assistant director of nursing (ADON) stated the facility has a binder with the procedure for obtaining medications that are controlled substances. The ADON stated if a medication is unavailable, staff are expected to check the emergency kit, reach out to the pharmacy, and reach out to the provider. The ADON stated she expects continued communication until the medication is available. The ADON confirmed the documentation the medication was not available. She stated she would expect the nursing staff to communicate with the providers at least every shift until the situation was rectified. The ADON confirmed the medical director was at the facility on 6/4/26 to certify R37's admission orders and the nurse practitioner saw R37 on 6/10/26 for an acute visit. The ADON confirmed there was no evidence a provider was notified of the clonazepam between the fax on 6/4/26 and the SBAR written 6/14/26. She stated the facility had ample opportunity to reach out to the providers to obtain the script for the clonazepam. A policy titled Procedure for Addressing Controlled Substance/Narcotic Supply shortage dated 11/5/25, indicated if it is a med we have in the emergency kit, first call the pharmacy (after hour pharmacy if that is appropriate) to see if you can access the emergency kit for the medication, if they say yes, do so and document/request replacement accordingly. But you will need to send a request for a refill if the pharmacy is not planning on sending more to the facility. If no, because there is not a valid Rx [prescription], then you will have to call the provider or the on-call provider for after hours. If they do it, ask them to be sure to send it to [pharmacy name]. It is then necessary to document what you have done and what the result is. If for some reason you are not able to get a medication, you need to monitor the resident, offer non-pharmacological interventions, and if that is not enough, call the family to notify and send the resident to the ED (emergency department). Notify facility DON by phone or email.