DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2022

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: CCN: 245375
Cycle Start Date: September 8, 2022

Dear Administrator:

On September 8, 2022, 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 December 8, 2022 (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 March 8, 2023 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	142 NORTH FIRST STREET WAITE PARK, MN 56387

(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
E 000	Initial Comments On 9/6/22 through 9/8/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/6/22 through 9/8/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED , however NO deficiencies were cited due to actions implemented by the facility prior to survey: H53754474C (MN00086002) H5375058C (MN00082629) H5375057C (MN00079485) H53754538C (MN00086594) The following complaints were found to be UNSUBSTANTIATED: H5375059C (MN00070166) H53754454C (MN00084868)	F 000		

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

Electronically Signed | 09/30/2022

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 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		10/3/22

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F 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignity by not removing facial hair for 2 of 3 residents (R5 and R22) who were dependent upon staff for shaving assistance. Findings include: R5's admission MDS dated 6/22/22, identified moderate cognitive impairment and required extensive assistance with personal hygiene. R5's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 6/28/22 identified R5 required minimum to moderate assistance with shaving. R5's care plan dated 6/28/22 indicated R5 had an ADL Self Care Performance Deficit related to weakness, falls and failure to thrive at home alone. R5's care plan goal included, "Groomed according to personal preference on a daily basis as condition allows through the review date."	F 550	(Sterling Park Health Care Center) denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 550, Resident's Rights/Exercise of Rights, Sterling Park Health Care Center	

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F 550	Continued From page 3 During initial observation on 9/6/22, at 12:58 p.m. R5 was sitting in recliner in room. R5 was noted to have gray and black whiskers about half inch long on cheeks, chin and neck. R5 stated he did not like having hair on his face, would like to be shaved but did not know where a razor was. On 9/7/22, at 9:54 a.m. R5 was observed to still unshaven. On 9/7/22, at 3:37 p.m. R5 returned from the shower room and was observed to be unshaven. On 9/7/22 at 3:45 p.m. R5 was ambulating down the hallway, was asked by a staff member if he would like to be shaved. R5 stated He would like that, "or I'll start looking like Santa." R5 was informed someone would assist him with shaving. On 9/8/22, at 7:54 a.m. R5 was in main dining room, was observed still unshaven. R5 stated that nobody had gone to his room to shave him. During an interview on 9/8/22, at 9:51 a.m. NA-A stated shaving should be done daily, NA-A stated she had assisted R5 with morning cares. NA-A stated R5 was really overdue for a shave but had not completed it. When interviewed on 9/8/22, at 12:28 p.m. registered nurse (RN)-A stated shaving was done when needed, at least on bath days. RN-A further stated if R5 stated he wanted to be shaved he was not one that would change his mind. R22's quarterly Minimum Data Set (MDS) dated 8/8/22, identified severe cognitive impairment	F 550	corrected the deficiency by providing facial hair grooming to R5, R22, and all like residents as preferred by each resident. An initial review was completed for all resident's facial hair grooming preferences and care plans updated as needed by 10/3/2022 by ED/designee. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 10/3/2022 on resident's right for preferred facial hair grooming by ED/designee The ED and/or designee will audit 4 residents per week x 2 weeks and then 2 residents weekly x 2weeks, then PRN to ensure continued compliance. 3. As part of Sterling Park Health Care Center ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.	

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F 550	Continued From page 4 with a diagnosis of dementia and was dependent upon staff for personal hygiene. R22's Care Plan (last reviewed 8/11/22) indicated: "R22 has an ADL Self Care Performance Deficit [related to] end stage dementia with behavioral disturbances, [osteoarthritis / degenerative joint disease], impaired mobility, impaired vision/hearing, and refusal of cares." R22's care plan goal: "R22 will be dressed and groomed according to personal preference on a daily basis as condition allows through the review date." Facility developed approaches included: "Encourage R22 to participate to the fullest extent possible with each interaction as she is able and willing" and "PERSONAL HYGIENE: Encourage R22 to comb or brush own hair and wash face. Provide demonstration, cueing and encouragement as necessary. [Assist of 1 staff] as she allows for tasks she is unable/unwilling to complete. During initial observation on 9/6/22, 12:45 p.m. R22 was noted to have multiple facial hairs on both sides of her chin which were long, and curling, approximately 1/2 - 1 inch in length. When interviewed on 9/6/22, at 2:30 p.m. R22's family member (FM)-A stated, R22 would not like to have facial hair, it would be embarrassing. During ongoing observation on 9/6/22 between 3:00 p.m. and 7:30 p.m., 9/7/22 between 8:30 a.m. - 3:30 p.m. and 9/8/22 between 6:25 a.m. - 7:18 a.m. R22 was observed still unshaven with the long facial hairs. When interviewed on 9/8/22, at 7:34 a.m. nursing assistant (NA)-B states she had been working	F 550		

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F 550	Continued From page 5 with R22 this week and had completed morning cares. NA-B stated R22 was dependent on cares, and did refuse at times, but accepted cares this a.m. When asked if there were any residents, including R22, on the unit that required assistance with shaving, NA-B stated "no, not down here." During an observation of R22 with the interim director of nursing (IDON) with subsequent interview on 9/8/22, at 9:09 a.m. IDON observed R22's long facial hair on resident's chin. IDON verified R22 was in the need of shaving, and stated "there is a 50/50 chance she would refuse to let staff provide cares, including shaving." IDON asked R22 if she knew she had long facial hair and wished to be shaved. R22 responded to IDON, "yes." IDON informed R22 she would make arrangements to have this completed. On 9/8/22, at 1:30 p.m. the facility was requested to provided a policy and/or procedure for resident ADL care provision. The facility administrator (ADM) stated the facility did not have a policy, and resident care instructions were included when doing training of staff for each resident assigned.	F 550		

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	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual recertification Life Safety Code Survey was conducted on 09/07/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Sterling Park Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/2022

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as 1 building: The Sterling Park Healthcare Center is a 1 story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963, that was determined to be of Type II(000) construction. In 1983, an addition was added to the dining room that was determined to be of Type II(000) construction. In 2003 an addition was added to the east that was determined to be of Type II(111) construction. In 2010 a enclosed courtyard addition was add that was determined to be of	K 000		

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K 000	Continued From page 2 Type II(111) construction. The building is fully sprinklered throughout and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a licensed capacity of 40 and had a census of 37 at the time of the survey. The requirements at 42 CR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222		10/3/22

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K 222	Continued From page 3 electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the proper operation of	K 222	Sterling Park Health Care Center denies it violated any federal or state regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	**142 NORTH FIRST STREET** **WAITE PARK, MN 56387**

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K 222	Continued From page 4 delayed egress exit door locking device systems per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/07/2022, at 10:45 AM, it was revealed by observation that the emergency exit door located by resident room W-13 is equipped with a delayed egress locking device that did not unlock when the delayed locking hardware was tested for 15, 30, or 45 seconds. The delayed egress locking device did unlock with fire alarm activation, remote release button, and with the alarm keypad located at the door. An interview with Maintenance Manager verified these deficient findings at the time of discovery.	K 222	Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 222, egress doors. The Sterling Park Health Care Center corrected the deficiency by adjusting the southwest exit door to function properly on 9/8/2022. 2. To correct the deficiency and to ensure the problem does not recur maintenance director of designee will audit all egress doors weekly for four weeks then monthly thereafter. 3. As part of Sterling Park Health Care Center ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns through the community's QA Process.	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category	K 901		10/3/22

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	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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K 901	Continued From page 5 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/07/2022, at 10:00 AM, it was revealed during a review of available documentation and an interview with the Maintenance Supervisor, that the utility risk assessment document provided at the time of the survey did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	Sterling Park Health Care Center denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 901, NFPA 99 Facility Risk Assessment. The Sterling Park Health Care Center corrected the deficiency by updating the NFPA 99 Facility Risk Assessment to include chapters 10 and 11. 2. As part of Sterling Park Health Care Center ongoing commitment to quality	

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	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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K 901	Continued From page 6	K 901	assurance, the Maintenance Director and/or designee will report identified concerns through the community's QA Process.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 22, 2022

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: CCN: 245375
Cycle Start Date: September 8, 2022

Dear Administrator:

On October 5, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us