



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2026

Administrator
STERLING PARK HEALTH CARE CENTER
142 NORTH FIRST STREET
WAITE PARK, MN 56387

RE: CCN: 245375

Cycle Start Date: August 6, 2026

Dear Administrator:

On August 6, 2026, 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:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

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 November 6, 2026 (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 February 6, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

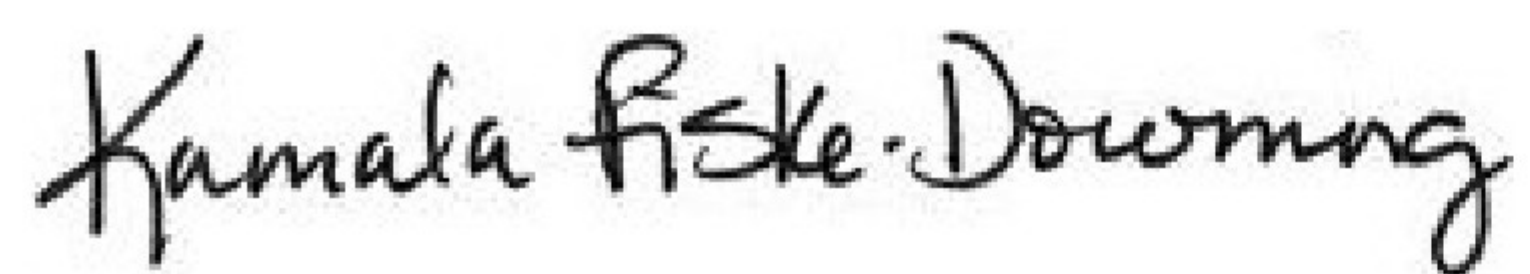
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/05/2026, 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) 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. 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			K0000			09/22/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 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. Building Info: 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 an enclosed courtyard addition was add that was determined to be of Type II(111) construction. The facility has a capacity of 40 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.			K0000			09/22/2026
K0374 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides			K0374	Sterling Park Healthcare Center corrected the deficiency by repairing the door by linens room A2 on 8/5/2026. All other smoke barrier doors were inspected to close properly by 9/22/2026. To ensure this does not recur all smoke barrier doors will be inspected weekly for 4 weeks to ensure proper closure.		09/22/2026

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K0374 SS = D Bldg. 01	Continued from page 2 a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 08/05/2026 at 10:52 AM, it was revealed by observation that the Smoke Barrier doors by Linen Room A2 did not close completely when released from the magnetic hold-open device leaving a gap at the top of the doors. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0374			09/22/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect rolling fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors Other Opening Protectives, section 5.2.5. This deficient finding could have an isolated impact on			K0761	Sterling Park Healthcare Center corrected the deficiency by having the rolling fire door inspected on 9/2/2026. However the door failed inspection at the fire links and is too old to get parts. The facility will reach out to an architect to determine if the rolling fire door is still needed with the building being fully sprinklered. Once confirmation is received the door will either be removed or fully replaced if it is required which would have several weeks of lead time. If the door is replaced and remains a rolling fire door the facility will complete education with the maintenance department on its required annual inspection to ensure continued compliance.		09/22/2026

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K0761 SS = D Bldg. 01	Continued from page 3 residents within the facility. Findings include: On 08/05/2026 at 11:18 AM, it was revealed by observation that the Rolling Fire Door in the serving window of the main kitchen had not been inspected within the last 12 months. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0761			09/22/2026



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Electronically Delivered
October 1, 2026

Administrator
STERLING PARK HEALTH CARE CENTER
142 NORTH FIRST STREET
WAITE PARK, MN 56387

RE: CCN: 245375
Cycle Start Date: August 6, 2026

Dear Administrator:

On September 30, 2026, 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,

A handwritten signature in cursive script that reads '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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 56387			
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E0000	Initial Comments On 8/3/26 through 8/6/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.		E0000			09/22/2026	
F0000	INITIAL COMMENTS On 8/3/26 through 8/6/26, a standard recertification survey (S5375041) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53753523C (229050762); H53753522C (247749064); H53753521C (256330825); H53753521C (256334244, 2988416, 2988502); H53753520C (257907789). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				

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 reverse for further 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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F0550 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 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 ensure residents' grooming needs were met for 1 of 2 residents (R12) in the sample who were observed for the provision of activities of daily living cares.			F0550	1.Sterling Park Healthcare Center corrected the deficiency by assisting R12 with shaving her face on 8/6/2026. All like residents were reviewed to ensure their facial hair preferences were added to the resident care sheet by 9/22/2026. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 9/22/2026 on the resident rights for preference on facial hair and location of preference on care sheet by DON/designee. The DON and/or designee will audit 2 residents weekly for 4 weeks to ensure grooming preferences were followed. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026

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F0550 SS = D	Continued from page 2 Findings include: R12's electronic health record (EHR) printed 8/6/26, indicated R5's diagnoses included; acute respiratory failure with hypoxia (the bodies tissues do not get enough oxygen to function), pleural effusion (an abnormal buildup of fluid between the tissues that line the lungs and the inside of the chest cavity), repeated falls, and wedge compression fractures of T11-T12 vertebra. R12's quarterly Minimum Data Set (MDS) dated 8/6/26, indicated R12 was cognitively intact and required partial-moderate assistance from facility staff for her grooming needs. On 8/3/26 at 10:34 a.m., R12 had multiple 1/4-inch whiskers on both corners of her chin. R12 stated she was unaware the whiskers where there and felt her chin. R12 stated "You're the first person to ask me about that. I have a razor. I don't like hair on my face. Can you help me with that?" R12 stated she was assisted that morning, but no one offered to shave her or mentioned she had chin hair. A nursing assistant care sheet, undated, indicated R12 required one assist with dressing, hygiene, and oral care. R12's EHR task section indicated "Shaving (electric/razor)" was assigned to the nursing assistants and was to be done "as needed". On 8/4/26 at 12:22 p.m., R12 pointed to her chin and stated, "no one has offered yet".On 8/5/2026 at 8:54 a.m., R12 was in her room waiting for breakfast and watching TV. R12 pointed to both side of her chin and stated, "Have you found out anything about these yet? No one has said or offered to help with it. Am I going to have to have them surgically removed?", and then she chuckled. During an interview on 8/5/26 at 9:29 a.m., nursing assistant (NA)-A stated she has offered to set up / lay out R12's shaver (electric - in the bedside stand) but she always refused. NA-A further stated, "We have offered and she refused, even offered to assist her and she refused." During an observation on 8/6/26 at 8:37 a.m., R12 was in her room placing her hearing aids into the charger case. R12 looked up and stated, "I still got these" as she rubbed her chin. She stated her morning cares had been completed earlier and "no one said anything." During this conversation, the director of nursing (DON) knocked and entered R12's room. DON asked if there was something she could assist with. R12 pointed to her chin and stated, "I want these gone". DON stated she had a razor and found the razor in R12's bedside stand with the battery compartment door missing and no batteries. R12 stated, "You just have to get some batteries and put some tape over them to hold them in". DON got batteries and shaved R12's chin.			F0550			09/22/2026

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F0550 SS = D	Continued from page 3 During an interview on 8/6/26 at 9:09 a.m., DON stated R12 had admitted to the facility a couple of times before, and resident had functioned at a high-level and did her own cares. DON stated the nursing assistants should have asked R12 and other residents if they needed help with shaving. DON was concerned that the staff had not noticed the shaver lacked batteries and the razor compartment door was missing. DON stated all the staff had to do was ask, and DON stated it caused her to wonder how long the razor had been that way. The facility's Activities of Daily Living (ADLs) policy, updated 5/27/26, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			F0550			09/22/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other			F0582	1. Sterling Park Healthcare Center is unable to issue the ABN notice to R49 as they discharged from the facility on 2/9/2026. 2. To ensure the problem does not recur the MDS nurse responsible for providing the notice of Medicare non-coverage was re-educated by the ED on the facility NOMNC guideline by 9/22/2026. The ED and/or designee will audit 2 residents notice of non-coverage per week for 4 weeks to ensure the appropriate forms were provided. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026

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NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 56387			
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F0582 SS = D	Continued from page 4 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (CMS-10055) to 1 of 3 residents (R49) reviewed for beneficiary notices. Findings include: R49's electronic health record (EHR) indicated Medicare Part A coverage for skilled nursing facility services ended on 2/2/26. Following the end of Medicare Part A coverage, R49 remained in the facility and transitioned to private-pay status. R49's EHR and beneficiary notice documentation lacked evidence that a completed SNFABN (CMS-10055), had been provided to R49 and/or R49's representative when Medicare Part A covered ended and R49 became financially responsible for continued services. During an interview on 8/4/26 at 11:32 a.m., the Assistant Director of Nursing (ADON) confirmed SNFABN, CMS-10055, had not been completed for R49. The ADON stated she was new to the role and had not been aware that an SNFABN was required. The ADON stated R49 had been expected to transfer to another setting; however, the transfer had been delayed after R49 developed COVID-19. The ADON confirmed an SNFABN should have been completed			F0582			09/22/2026

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F0582 SS = D	Continued from page 5 to inform R49 of his financial responsibility when he transitioned to private-pay status. When requested to provide the facility policy related to beneficiary notices, the facility provided an undated Beneficiary Notice Guidelines document. The guidelines indicated when a Medicare Part A stay ended because the provider determined the beneficiary no longer required daily skilled services, the beneficiary had skilled benefit days remaining, and the beneficiary was discharged from Medicare Part A but continued to reside in the facility under a different payer source, beneficiary notices were issued. The guidelines identified the SNFABN, CMS-10055 and a Notice of Medicare Non-Coverage (NOMNC), CMS-10123, as types of beneficiary notices to be issued.		F0582			09/22/2026	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .		F0605	1. Sterling Park Healthcare Center corrected the deficiency by completing orthostatic blood pressures on R31 on 9/10/2026 and all like residents on antipsychotics by 9/22/2026. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated by 9/22/2026 on the facility order supplemental documentation expectation related to orthostatic blood pressures by ED/DON. The DON and/or designee will audit 4 residents on antipsychotic medications weekly for orthostatic blood pressure completion for 4 weeks. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026	

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F0605 SS = D	Continued from page 6 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;			F0605			09/22/2026

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F0605 SS = D	Continued from page 7 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure potential adverse consequences associated with antipsychotic medication use were adequately monitored when orthostatic blood pressures were not completed as ordered for 1 of 3 residents (R31) reviewed for unnecessary medications. Findings include: R31 R31's quarterly Minimum Data Set (MDS) dated 7/2/26, identified R31 had intact cognition and required assistance with activities of daily living (ADL)'s. R31's diagnoses included non-Alzheimer's dementia (permanent decline in mental abilities), Parkinson's disease (long-term brain disorder that slows and impairs movement as specific nerve cells die), bipolar disorder (a mental health condition defined by at least one full manic episode, which is a period of abnormally high energy, extreme excitement, or intense irritability) and repeated falls. MDS indicated R31 received antipsychotic			F0605			09/22/2026

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F0605 SS = D	Continued from page 8 medications (used to treat symptoms of psychosis, such as hallucinations and delusions, by balancing brain chemicals). R31's physician orders identified quetiapine fumarate, an antipsychotic medication, 300 milligrams (mg) by mouth at bedtime for bipolar I disorder, initiated on 10/23/25; quetiapine fumarate 50 mg by mouth every morning for bipolar I disorder, initiated on 10/24/25; and quetiapine fumarate 50 mg by mouth every six hours as needed (PRN) for bipolar I disorder with manic episodes for 13 days, initiated on 8/4/26. R31's progress noted dated 3/17/26 at 9:20 a.m. indicated orthostatic blood pressure was not completed because R31 was "unable to stand". R31's progress noted dated 4/17/26 at 9:33 a.m. indicated orthostatic blood pressure was not completed because R31 was "unable to stand". R31's progress noted dated 5/17/26 at 9:17 a.m. indicated orthostatic blood pressure was not completed because R31 was "unable to stand". R31's progress noted dated 6/18/26 at 9:03 a.m. indicated orthostatic blood pressure was not completed because R31 was "unable to stand". R31's electronic health record (EHR) lacked evidence staff obtained blood pressures in the positions R31 was able to tolerate, including lying and sitting, when a standing measurement could not be obtained. As a result, the scheduled orthostatic blood pressure monitoring was not completed during March, April, May or June 2026. During an interview on 8/6/26 at 8:53 a.m., licensed practical nurse (LPN)-A stated orthostatic blood pressure monitoring consisted of obtaining blood pressure measurements while the resident was lying, sitting, and standing. LPN-A stated when a resident was not able to stand, staff would obtain the blood pressure measurements while the resident was lying and sitting. LPN-A further stated if a resident refused the monitoring, staff would reattempt the monitoring and document the refusal. During an interview on 8/6/26 at 10:10 a.m., the registered nurse case manager (RN)-A stated orthostatic blood pressures were completed by the floor nurse. RN-A stated that if a resident was unable to stand, staff should still obtain blood pressure measurements while the resident was lying and sitting and document the resident's inability to			F0605			09/22/2026

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F0605 SS = D	Continued from page 9 stand. RN-A stated orthostatic blood pressure monitoring was important for resident receiving psychotropic medications to monitor for potential adverse effects. During an interview on 6/4/26 at 12:14 p.m., RN Case Manager (CM)-C stated orthostatic blood pressures should be completed monthly and include blood pressure measurements in the lying, sitting, and standing positions. CM-C stated orthostatic blood pressures were important because antipsychotic medications could cause side effects that increased a resident's risk for falls. CM-C stated they would not expect blood pressure readings to be exactly the same in all three positions because some variation would typically occur. CM-C further stated that if a resident refused the monitoring, staff should document the refusal and attempt the monitoring again later. CM-C reviewed the orthostatic blood pressure documentation for the identified residents and confirmed several readings were identical in all positions. CM-C stated they would ensure nursing staff were educated on the correct procedure for obtaining orthostatic blood pressures. During an interview on 8/6/26 at 9:55 a.m., a call was placed to the consultant pharmacist, and a message was left requesting a return call regarding psychotropic medication monitoring and orthostatic blood pressure monitoring. As of survey exit, the consultant pharmacist had not returned the call. During an interview on 8/6/26 at 10:39 a.m., director of nursing (DON) stated residents receiving psychotropic medications were expected to have orthostatic blood pressure monitoring completed monthly, when they were able to participate. The DON stated orthostatic blood pressure monitoring consisted of obtaining blood pressure measurements while the resident was lying, sitting, and standing when the resident was able. The DON stated that when a resident was unable to stand, staff were still expected to obtain the lying and sitting blood pressure measurements. The DON stated orthostatic blood pressure monitoring was important to identify dizziness and adverse effects associated with medications that could increase a resident's risk for falls. The facility policy, "Use of Psychotropic Medication(s)", "updated 4/21/25, indicated psychotropic medications were to be used when appropriate for the resident's diagnosed condition and their benefit demonstrated through monitoring and documentation of the resident's response to the			F0605			09/22/2026

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F0605 SS = D	Continued from page 10 medication. The policy indicated the effects of psychotropic medications on the resident's physical, mental, and psychosocial well-being were to be evaluated on an ongoing basis, including through nursing assessments and medication-monitoring parameters consistent with clinical standards of practice, manufacturer specifications, and the resident's comprehensive care plan. The policy further indicated the resident's response to the medication, including the presence or absence of adverse consequences, was to be documented in the medical record.			F0605			09/22/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was			F0656	1. Sterling Park Healthcare Center was unable to correct R25 care plan as the resident was discharged from the facility. All like residents who smoke had their care plan reviewed for accuracy by 09/22/2026. 2. To correct the deficiency and to ensure the problem does not recur all nurse leadership staff were educated by 9/22/2026 on the Accura Comprehensive Care Plan policy by ED/DON. The DON and/or designee will audit all resident care plans of those who smoke weekly for 4 weeks to ensure they are accurate. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026

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F0656 SS = D	Continued from page 11 assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive resident care plan was completed for 1 of 3 residents (R25) reviewed for smoking. Findings include: R25's electronic health record (EHR) diagnosis list printed 8/6/26, indicated R25's diagnoses included emphysema (a long-term lung disease where the tiny air sacs in lungs are harmed), dependence on oxygen, chronic obstructive pulmonary disease (COPD), and tobacco use. R25's comprehensive Minimum Data Set (MDS) dated 6/29/26, indicated R25 was cognitively intact and dependent on facility staff for her activities of daily living (ADLs). On 8/3/26 at 11:56 a.m., R25 was observed outside the skilled nursing facility, in front of the attached assisted living facility, smoking at the public bus stop shelter. R25 stated, "This is were we are to smoke." No skin or clothing burn marks were observed on R25, and resident held and disposed of her smoking materials safely. R25's Smoking and Safety assessment dated 7/7/26, indicated the facility had determined R25 was safe to smoke independently. The status of the assessment indicated "activating". R25's comprehensive care plan revised 7/19/26, indicated R25 had potential/actual impairment to skin integrity related to (r/t) decreased mobility from recent surgery, fragile skin due to aging and smoking, surgical wound from surgery, and R25 had altered respiratory status/difficulty breathing, shortness of breath related to COPD/emphysema. However, R25's care plan lacked the addition of a smoking section with interventions after R25 had been assessed on 7/9/26. During an interview on 8/4/26 at 4:20 p.m., assistant director of nurse (ADON) stated R25's care plan lacked documentation of R25 smoking. ADON reviewed R25's smoking assessment and noted that the care planning option was stuck on "activating".			F0656			09/22/2026

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F0656 SS = D	Continued from page 12 ADON stated the assessment, once the care plan option was activated, should send a message that a care planning problem needed to be addressed. The beginning of the month (July 2026) PCC was updated with new assessments {Nursing Advantage assessments) that provided the facility staff to be alerted to the need to address a resident concern. ADON stated she would contact the administrator of this issue. During an interview on 8/6/26 at 9:13 a.m., the director of nursing (DON) stated they had assessment updates the beginning of July 2026, and there appears to have been a "computer glitch", noting that the smoking assessment was still in the "activating" mode. DON stated, the facility staff should have reviewed the care plan after the assessment was completed, to personalize it to R25's smoking needs and habits. DON stated, even with this new feature, facility staff could still enter care plan problems manually. DON further stated, when a care plan is reviewed and revised, the entire care plan should be reviewed, to note if further revisions are needed. In review of the facility's policy, entitled: Comprehensive Care Plan (Updated 12/3/25) documented only the following: "e) The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The care plan will be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident's highest practicable physical, mental and psycho social well-being."		F0656			09/22/2026	
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure coordination and communication of dialysis-related care when staff did not notify the provider, nephrologist, or dialysis center, after a resident did not receive a prescribed dialysis-related medication for six consecutive days for 1 of 1 resident (R33) reviewed for dialysis services.		F0698	1. Sterling Park Healthcare Center corrected the deficiency by updating R33 primary provider and dialysis center regarding missed medication on 9/11/2026. The facility currently has no other like dialysis residents. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated on the facility dialysis policy and expectations of provider notifications with missed medications by ED/DON on or before 9/22/2026. The DON and/or designee will audit all dialysis residents weekly for 4 weeks to ensure appropriate communication occurs. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026	

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F0698 SS = D	Continued from page 13 Findings include: R33's admission Minimum Data Set (MDS) dated 7/18/26, identified R33 had intact cognition and required assistance with activities of daily living (ADL)'s. R33's diagnoses included. atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart beat chaotically and out of sync), heart failure (heart muscle is too weak or stiff to pump blood well, so the body does not get enough oxygen and blood backs up into the lungs or body), end-stage renal disease (permanent kidney failure where the kidneys stop working well enough to keep you alive, requiring dialysis or a kidney transplant), and dependence on renal dialysis (when a person relies permanently or long-term on a dialysis machine to stay alive because their kidneys can no longer function on their own). R33's electronic health record (EHR) indicated R33 received hemodialysis three days per week at an outpatient dialysis center. R33's physician orders printed 8/6/26, indicated calcium acetate (medication to treat high blood phosphate levels in residents with end-stage kidney disease who are on dialysis) 667 milligrams (mg) by mouth three times daily, initiated on 7/15/26. R33's medication administration record (MAR) for July 2026, indicated calcium acetate was not administered as ordered on 7/15/26, 7/16/26, 7/17/26, 7/18/26, 7/19/26, or for two scheduled doses on 7/20/26. R33 did not receive the prescribed calcium acetate for six consecutive days. R33's dialysis communication documentation dated 7/16/26, 7/18/26, and 7/21/26, lacked evidence that the facility notified the dialysis center of R33's missed doses of calcium acetate. R33's EHR lacked evident the provider or nephrologist was notified R33 had not received the prescribed calcium acetate from 7/15/26 through 7/20/26. During an interview on 8/6/26 at 8:53 a.m., licensed practical nurse (LPN)-A stated the provider and dialysis center should have been notified R33 had not received the medication. LPN-A stated the notification should have been documented in the progress notes. During an interview on 8/6/26 at 10:10 a.m., registered nurse case manager (RN)-A stated if a			F0698			09/22/2026

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F0698 SS = D	Continued from page 14 resident did not receive a medication, the provider should have been notified. RN-A confirmed nursing staff should have notified the dialysis center R33 had not received the medication. During an interview on 8/6/26 at 10:39 a.m., the director of nursing (DON) stated she was unaware R33 had not received calcium acetate. Nursing staff had not notified her the medication had not been delivered. After reviewing R33's progress notes, the DON confirmed the EHR lacked documentation the provider or nephrologist had been notified of the missed doses of calcium acetate. The facility's Dialysis: Care and Monitoring of Resident policy, dated 12/3/25, indicated the facility would provide adequate long-term access for dialysis, administer medications as ordered, and immediately report abnormal findings to the dialysis department and physician.			F0698			09/22/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			F0755	1. Sterling Park Healthcare Center corrected the deficiency by auditing all residents medication orders to ensure medication was on hand or had been addressed by 9/22/2026. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated by 9/22/2026 on the process and expectations for unavailable medications by ED/DON. The DON and/or designee will audit 2 random residents weekly for 4 weeks to ensure they have all ordered medications available for administration. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026

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F0755 SS = D	Continued from page 15 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a prescribed medication was available for administration and follow up when a medication remained unavailable from the pharmacy. This resulted in a resident not receiving the prescribed medication for six consecutive days for 1 of 1 resident (R33) reviewed for medication availability. Findings include: R33's admission Minimum Data Set (MDS) dated 7/18/26, identified R33 had intact cognition and required assistance with activities of daily living (ADL)'s. R33's diagnoses included. atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart beat chaotically and out of sync), heart failure (heart muscle is too weak or stiff to pump blood well, so the body does not get enough oxygen and blood backs up into the lungs or body), end-stage renal disease (permanent kidney failure where the kidneys stop working well enough to keep you alive, requiring dialysis or a kidney transplant), and dependence on renal dialysis (when a person relies permanently or long-term on a dialysis machine to stay alive because their kidneys can no longer function on their own). R33's physician orders printed 8/6/26, indicated calcium acetate (medication to treat high blood phosphate levels in residents with end-stage kidney disease who are on dialysis) 667 milligrams (mg) by mouth three times daily, initiated on 7/15/26. R33's medication administration record (MAR) for July 2026, indicated calcium acetate was not administered as ordered on 7/15/26, 7/16/26, 7/17/26, 7/18/26, 7/19/26, or for two scheduled doses on 7/20/26. R33 did not receive the prescribed calcium acetate for six consecutive days. R33's progress notes indicated the medication was unavailable from the pharmacy during this period: On 7/15/26 at 7:41 a.m. and 12:27 p.m., staff documented the medication had not been delivered by the pharmacy. At 5:09 p.m., staff documented the medication was unavailable and on order.			F0755			09/22/2026

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F0755 SS = D	Continued from page 16 On 7/16/26 at 11:38 a.m. and 11:39 a.m., staff documented the medication had not been delivered and no supply was available. On 7/17/26 at 7:13 a.m. and 11:00 a.m., staff documented the medication remained on order. On 7/18/26 at 3:35 p.m., staff documented no calcium acetate was available from the pharmacy. The progress note indicated staff contacted the pharmacy, and pharmacy personnel confirmed the medication was in the pharmacy's system and would be sent the following night. On 7/19/26 at 12:33 p.m. and 3:23 p.m., staff documented calcium acetate remained unavailable. On 7/20/26 at 12:38 p.m., staff documented the medication had not been delivered and the pharmacy had been contacted regarding delivery. R33's EHR lacked evidence that staff checked the emergency medication supply or took additional action to obtain calcium acetate from an alternative source when the medication remained unavailable. During an interview on 8/6/26 at 8:53 a.m., licensed practical nurse (LPN)-A stated when a medication was unavailable, nursing staff should have checked the emergency medication supply, contacted the pharmacy by telephone, and documented the communication. During an interview on 8/6/26 at 10:10 a.m., registered nurse case manager (RN)-A stated the facility's pharmacy was located in Iowa, and medications were delivered late in the evening. RN-A stated the facility had recently entered into an agreement with a local pharmacy to obtain medications when ordered medications were unavailable. RN-A stated when a nurse did not have a medication available, the nurse should have contacted the pharmacy to determine the reason and notified the director of nursing (DON) or RN-A the medication was unavailable. During an interview on 8/6/26 at 10:39 a.m., DON stated the pharmacy was located in Iowa, and the facility was working with the pharmacy to obtain medications more timely. The DON stated admission orders were sent to the pharmacy and medications identified as most important were sent to a local pharmacy under a new agreement so they could be obtained sooner. DON stated nursing staff should have contacted the pharmacy when the medication was unavailable and notified DON so she could also			F0755			09/22/2026

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F0755 SS = D	Continued from page 17 contact the pharmacy and attempt to obtain the medication sooner. The DON stated she had been unaware R33 had not received calcium acetate and nursing staff had not notified her the medication had not been delivered. After reviewing R33's July MAR, DON stated calcium acetate arrived on 7/20/26 and it appeared the facility did not have the medication available until it was delivered that day. The facility's Unavailable Medications policy, revised 11/18, indicated medications used by residents could occasionally be unavailable for dispensing from the pharmacy due to circumstances including the pharmacy being temporarily out of stock, a drug recall, a manufacturer's shortage of an ingredient, or discontinuation of the medication by the manufacturer. The policy indicated the facility was required to make every effort to ensure medications were available to meet each resident's needs.			F0755			09/22/2026
F0840 SS = D	Use of Outside Resources CFR(s): 483.70(f)(1)(2) §483.70(f) Use of outside resources. §483.70(f)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(f)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a written agreement was established with an outside dialysis provider that furnished dialysis services to facility residents. This deficient practice had the potential to affect all residents who received dialysis services at an outside facility.			F0840	1. Sterling Park Healthcare Center corrected the deficiency by obtaining a written agreement with the dialysis agency on 8/11/2026. 2. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/22/2026

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F0840 SS = D	Continued from page 18 Findings include: Review of facility documentation identified that residents received outpatient hemodialysis services from an outside dialysis provider. Review of facility contracts and agreements failed to identify a written agreement between the facility and the dialysis provider that defined the services provided and the responsibilities of the facility and the dialysis provider related to the residents' dialysis care. During an interview on 8/3/26 at 12:48 p.m., Administrator confirmed the facility did not have a written agreement or contract with the dialysis provider. Administrator stated an agreement or contract was not needed because the facility did not provide peritoneal dialysis on site. During an interview on 8/6/26 at 11:39 a.m., Administrator stated a contract or agreement with the dialysis provider was not needed. The Administrator stated that she did not know whom to contact regarding an agreement and that, if the facility was required to have one, the facility might stop admitting residents who received dialysis. The Administrator stated the facility did not arrange the dialysis services because the services had been arranged before the residents were admitted. The Administrator also stated the facility did not pay the dialysis provider and therefore, she saw no need for a contract/agreement unless dialysis services were provided in the facility. The facility policy titled Dialysis: Care and Monitoring of Resident, dated 12/3/25, indicated that the facility would provide adequate long-term access for dialysis and monitor for patency, infection, and bleeding. The policy also indicated that the facility would assess residents and evaluate changes in condition related to their physical condition upon return to the facility after receiving dialysis treatment. The policy did not identify a requirement for a written agreement with the outside dialysis provider or define the responsibilities of the facility and the dialysis provider for coordinating and providing dialysis-related care.			F0840			09/22/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control			F0880	1. Sterling Park Healthcare Center corrected the deficiency by educating NA-C and NA-B on ensuring the correct PPE is worn while providing cares for R2 and all like residents on enhanced barrier precautions by the DON by 9/22/2026.		09/22/2026

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F0880 SS = D	Continued from page 19 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			F0880	Continued from page 19 2.To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 9/22/2026 on the Accura Enhanced Barrier Precautions policy by ED/DON. The DON and/or designee will audit enhanced barrier precautions for 3 staff weekly for 4 weeks. 3. As part of Sterling Park Healthcare Center’s ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community’s QA Process.		09/22/2026

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F0880 SS = D	Continued from page 20 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facility staff followed the infection control practices for 1 of 2 resident (R2) in the sample who were review for activities of daily living (ADLs). Findings include - R2's Point Click Care (PCC - electronic medical record system) printed 8/6/26, indicated diagnoses included; acute respiratory failure with hypoxia (the bodies tissues do not get enough oxygen to function), traumatic subdural hemorrhage with loss of consciousness, cardio-vascular accident resulting in aphasia (the complete inability to swallow due to physical damage or muscle failure in the mouth, throat, or esophagus) and dysphagia (difficulty or discomfort when swallowing. It can range from mild trouble passing certain foods to a complete inability to swallow) and received nutrition though a gastric feeding tube. R2's quarterly Minimum Data Set (MDS) dated 7/30/26, indicated R6 was severely cognitively impaired and dependent on facility staff for all of resident's activities of daily living (ADLS). During general observations of R2's room, it was posted with "Enhanced Barrier Precautions" (EBP) signage (EBP = infection control guidelines used in nursing homes and long-term care facilities to stop the spread of dangerous germs called multidrug-resistant organisms (MDROs)). Within R2's room were gloves and disposable gowns to be used during direct care due to R2's gastric feeding tube. In an observation on 8/6/26 at 6:45 a.m., nursing			F0880			09/22/2026

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F0880 SS = D	Continued from page 21 assistant (NA)-B was already in R2's room providing morning cares. NA-B stated she was waiting on NA-C to return to assist with resident positioning to do back care. NA-B was wearing gloves, however no gown. NA-C entered the room shortly after, preformed hand hygiene and donned gloves. NA-C did not don a gown. NA-C then assisted NA-B, rolling R2 towards NA-C so NA-B could provide back side care. After R2's care was provided, R2 was dressed, and placed in her wheelchair using a Volaro brand lift. NA-B and NA-C removed their gloves and performed hand hygiene, with NA-B again donning gloves to perform R2's oral hygiene. In an interview on 8/6/26 at 7:42 a.m., NA-B and NA-C approached surveyor (while surveyor was called away to another observation) and stated they wanted to tell surveyor that they forgot to wear gowns while doing morning cares on R2. During this interview, both staff member stated it was important to have worn the gown, not only for R2's protection, but theirs and the other resident they would have been caring for after, due to her gastric feeding tube. During interview 8/6/26 at 9:11 a.m., the director of nursing (DON) was interviewed while the facility's infection preventionist was out. The DON stated the two nursing assistants should have worn gowns during the morning care of R2. DON stated the room had the postings and the PPE (personal protective equipment) and should have cued both nursing assistants to wear. In review of the facility's Infection Control Manual (last reviewed 1/29/26) on page 55 it documented the following: "a) Staff must wear a gown, or an apron when performing task(s) that will likely soiled employee's clothing with infective matter (i.e.: blood, feces, body fluid, tissue, etc.)" And on Page 58, "Enhanced Barrier Precautions": "c) section 2 PPE for enhanced barrier precautions is only necessary when performing high -contact care activities and may not be needed to be donned prior to entering the resident's room"			F0880			09/22/2026