MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6832
April 21, 2017

Mr. Jason Hoyt, Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

Subject: Sterling Park Health Care Center - IDR
Provider # 245375
Project # S5375027

Dear Mr. Hoyt:

This is in response to your letter of November 15, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F309 issued pursuant to the survey event 68XF11, completed on October 21, 2016.

The information presented with your letter, the CMS 2567 dated October 21, 2016, and corresponding Plan of Correction, a face to face meeting with the facility on January 12, 2017, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F309 (G) 42 CFR § 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Summary of the facility's reason for IDR of this tag.

The facility alleges staff took appropriate action with R34, including contacting the physician with her change in condition, making follow up calls to the physician, monitoring the resident, discussing her health care status with R34 and her family, and sending the resident to see a health care provider while previous attempts to contact him via phone calls and/or faxes remained unanswered. The facility also maintained the physician acknowledged receipt of the fax regarding the resident's weight gain and changing medical status prior to her appointment visit, and at the scheduled visit, a nurse practitioner performed a physical examination of the resident, completed a chest x-ray, and sent her back to the facility with no change in orders, no further instructions, or concerns noted.

Summary of facts.

R34 was admitted to the facility on 9/13/16, following an inpatient hospitalization stay. R34's discharge summary indicated the reason for her hospital stay was seizures (resolved), failure to thrive in adult, and hyponatremia. A list of diagnoses on discharge included chronic diastolic heart failure (CHF) – present. R34's discharge orders included to call the physician if there was a weight gain of 3 pounds or more overnight, or a 5 pound gain in a week. The orders also placed R34 on a 1000 cc fluid restriction. The facility failed to monitor R34's fluid intake. The facility also failed to monitor daily weights from 9/16/17 through 9/22/17, and 9/24 to 9/25/17. R34 was weighed on 9/26/17, and had incurred an 8 pound weight gain in 3 days. R34 complained of not feeling well on 9/26/17, and the facility sent a fax to her physician, however, the fax lacked information on R34's 8 pound weight gain. R34's physician stated he had sent a fax back to the facility on 9/26/16, with orders for Lasix, labs, a chest x-ray, and to send R34 to the emergency room if her condition worsened. The physician stated if the facility had not heard back from him, they should have contacted him by telephone. The facility did not receive a response from the physician, and after talking with R34 and her family on 9/27/17, sent her to see a nurse practitioner on 9/28/16. A chest x-ray was completed at that time, with the impression of fluid overload/CHF. R34's condition continued to deteriorate, and she was hospitalized on 10/1/16, for acute hypoxic respiratory failure related to acute on chronic diastolic CHF.

Summary of findings

This is a valid deficiency at this tag and at the correct scope and severity level of a G.

This concludes the Minnesota Department of Health informal dispute resolution process.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Teresa Ament

Teresa Ament, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: (218) 302-6151 Fax: (218) 723-2359

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Brenda Fischer, St. Cloud Team A Unit Supervisor

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 68XF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00643

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245375**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502490100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STERLING PARK HEALTH CARE CENTER**
(L4) **142 NORTH FIRST STREET**
(L5) **WAITE PARK, MN** (L6) **56387**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/28/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Mandatory DOPNA, effective1/5/2017, is rescinded effective 11/28/2016.

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/24/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY	**00**	INVOLUNTARY
01-Merger, Closure		05-Fail to Meet Health/Safety
02-Dissatisfaction W/ Reimbursement		06-Fail to Meet Agreement
03-Risk of Involuntary Termination		OTHER
04-Other Reason for Withdrawal		07-Provider Status Change
		00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2016
(L33)

DETERMINATION APPROVAL

MDH
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245375
January 24, 2017

Mr. Jason Hoyt, Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

Dear Mr. Hoyt:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 28, 2016 the above facility is certified for or recommended for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

Mr. Jason Hoyt, Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: Project Number S5375027 & H5255039

Dear Mr. Hoyt:

On December 23, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 15, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on October 21, 2016, that included an investigation of complaint number H5255039, and failure to achieve substantial compliance by the 65th day of the enforcement cycle. The most serious deficiencies at the time of the survey and investigation were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 27, 2016, the Office of Health Facility Complaints and on December 28, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 21, 2016 and a complaint investigation completed on November 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 28, 2016, and the complaint investigation completed November 15, 2016, as of November 28, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 28, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of December 23, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 21, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 21, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 21, 2017, is to be rescinded.

In our letter of December 23, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 28, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245375 Y1	A. Building B. Wing Y2	12/28/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0166	Correction	ID Prefix F0225	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(f)(2)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC	11/25/2016	LSC	11/25/2016	LSC	11/25/2016
ID Prefix F0226	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	11/25/2016	LSC	11/25/2016	LSC	11/25/2016
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0325	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed
LSC	11/25/2016	LSC	11/25/2016	LSC	11/25/2016
ID Prefix F0332	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.25(m)(1)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	11/25/2016	LSC	11/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	01/24/2017	33925	12/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 68XF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00643

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245375**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502490100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STERLING PARK HEALTH CARE CENTER**
(L4) **142 NORTH FIRST STREET**
(L5) **WAITE PARK, MN** (L6) **56387**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/21/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 11/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/22/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 10, 2016

Mr. Jason Hoyt, Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: Project Number S5375027

Dear Mr. Hoyt:

On October 21, 2016, a standard 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on October 21, 2016. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 15, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 January 21, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

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 _____	10/21/2016

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
F 000	INITIAL COMMENTS On 10/17/16 to 10/21/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Sterling Park Health Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		11/25/16

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

Electronically Signed | 11/14/2016

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of weight gain according to physician orders, for 1 of 1 residents (R34) who had congestive heart failure. Findings include: R34's admission Minimum Data Set (MDS) dated 9/20/16, indicated she admitted to the facility on 9/13/16. The MDS indicated she was cognitively intact had diagnosis of heart failure, hypertension and chronic obstructive pulmonary disease. R34's Diagnosis Report indicated she had heart failure with a onset date of 5/25/11. R34's care plan dated 10/03/16, indicated she had congestive heart failure and directed staff to monitor weights daily and updated per parameters or facilty protocol and to	F 157	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R34 has been discharged form the facility. 2. Physician Orders were reviewed for all residents. Residents with orders for daily weights were verified and discussed with their primary MD's. Adjustments were made and weight parameters re- set	

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F 157	Continued From page 2 observe/document to medical practitioner as needed any signs or symptoms of congestive heart failure, dependent edema of legs and feet, crackles and wheezes, weakness and fatigue. R34's Orders Discharge Report dated 9/13/16, indicated an order to call your physician if you gain 3 lbs or more over night, or gain 5 pounds in a week. Review of R34's Weights and Vitals Summary form from 9/13/16 to 10/01/16, indicated the following" 9/14/16- 197 lbs 9/15/16- 197 lbs 9/16/16- no weight recorded 9/17/16-no weight recorded 9/18/16- 196 lbs 9/19/16- 196 lbs 9/20/16, 9/21/16 and 9/22/16 - no weights recorded 9/23/16- 196 lbs 9/24/16 and 9/25/16 - no weights recorded 9/26/16-204 lbs - 8 lb weight gain 9/27/16- 204 lbs 9/28/16 and 9/29/16- no weights recorded 9/30/16- 205 lbs A Fax dated 9/30/16, no time listed. Indicated an update on residents weights today was 205 lbs, back on 9/23/16, was 196 lbs continues to need oxygen at two liters to maintain oxygen saturations greater than 90%. Has not been compliant with fluid restriction of 1000 cc/day and met that by lunch yesterday. Currently not on any diuretics. This was the first notice in the medical record that R34's physician had been notified of the weight gain that occurred on 9/26/16. The chart further lacked any physician response to	F 157	per each residents primary MD's recommendations/orders. 3. The facilities guidelines for "Change in Condition – When to report to the MD/NP/PA" were reviewed. All nursing staff have been re-educated on the guidelines regarding change of condition and physician notification with special focus on weight gain/loss. 4. The DNS or designee will complete audits 3 x week for 1 month and then weekly x2 months to ensure daily weights have been obtained and reviewed with appropriate and timely notifications given to the MD. Audit results and the data collected will be presented to the QAPI committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective Action will be completed by November 25th, 2016	

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F 157	Continued From page 3	F 157		

this fax even though R34 had a weight gain of 8 pounds, needing continuous oxygen to maintain oxygen saturations.

A fax sent to the facility 10/1/16, from residents primary physician at 12:35 p.m. stated "Send to ER (emergency room) for eval."

During interview 10/19/16, at 4:04 p.m. registered nurse (RN)-B who stated there was missing weights. RN-B stated the nursing staff who are on the medication carts are responsible for the daily weights and notification of the weight gain. RN-B stated she was on the medication cart on 9/30/16, and weighed the resident and sent a fax to the MD notifying him of the weight gain.

A Hospitalist History And Physical dated 10/1/16, at 5:34 p.m. indicated R34 stated she noticed some shortness of breath last night and this morning it was fairly severe. It was accompanied by some chest tightness. She has a cough productive of white sputum. Mild subjective fever. No chills. No nausea or vomiting. No diarrhea. She does not feel that she has gained weight though her discharge weight from 9/13/16 and today show a 17 pound weight gain. While changing into a hospital gown her oxygen saturations dropped to 71%. Patient was given 80 mg (milligrams) of lasix intravenously, started on BIPAP (bilevel positive airway pressure, continues positive airway pressure). The patient was admitted to the hospital from 10/1/16 to 10/06/16.

A St. Cloud Hospital Orders Discharge Report dated 10/06/16, indicated she was hospitalized for heart failure, and staff to weigh daily and report if you gain 3 lbs or more overnight, or gain

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F 157	Continued From page 4	F 157		

5 pounds in a week. The orders indicated she was to be weighed daily for consideration of lasix changes, was placed on a 2000 cc fluid restriction and to contact the physician if she had shortness of breath, swelling of feet, decreased exercise tolerance and/or excessive tiredness.

During interview 10/20/16, at 11:21 a.m. the facility director of nursing (DON) stated on 9/26/16 R34 was gaining weight and they faxed her MD but they did not get a response so the nurses called back and still no response. The resident then had a care conference on 9/27/16 and it was decided to have her be seen so an appointment was made for 9/28/16 and a chest x-ray was ordered, she worsened and was hospitalized. The DON was unable to identify in the medical record the physician was notified of the 8 lb weight gain until 9/30/16, right before the resident was hospitalized.

During telephone interview 10/20/16, at at 1:28 p.m. with R34's primary physician stated he was to be notified of weight gains, was on a fluid restriction that should be monitored. He placed these parameters to prevent re-hospitalization.

During telephone interview 10/21/16, at 9:00 a.m. the facility pharmacist reviewed the information, and stated that physician notification and follow thru of the residents weight gains were concerns.

Although R34 had physician orders to have her fluids monitored, daily weights and parameters to notify the physician for weight gain, R34 had a 8 pound weight gain that occurred on 9/26/16, but the physician was not notified until 9/30/16 of the weight gain.

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F 157	Continued From page 5 A facility Change In Condition When To Report To The MD/NP/PA undated indicated to report to them immediately of weight gain associated with respiratory symptoms, weight gain or >3 lb. in one day or 5 lb. in one week. The report further indicated to notify of abrupt onset of shortness of breath with pain, fever or respiratory distress.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to resolve a grievance timely for 1 of 1 residents (R32) who complained a missing clothing item had not being found. Findings include: R32's quarterly Minimum Data Set (MDS) dated 8/24/16, indicated she was cognitively intact. During interview 10/18/16, at 5:16 p.m. R32 stated she had a dress that went missing back in December. R32 showed a picture on her bulletin board of her at a Christmas party wearing the dress. R32 stated she had reported it to the laundry and they still have not found it. During interview 1018/16, at 6:26 p.m. the facility licensed social worker (LSW), stated she keeps the logs if a resident has something missing and	F 166	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R32 had missing item found prior to end of survey 2. All Feedback Forms for the past 3 months have been reviewed for Missing Property. Any residents identified with missing items have been followed up with and items found/replaced as able. 3. The facilities Feedback Form and	11/25/16

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F 166	Continued From page 6 that she was not aware that R32 had a missing dress and that no one had reported this to her. During interview 10/19/16, at 10:30 a.m. LSW stated she called R32's family about R32's missing dress. The family came in, talked to the resident, and found out the missing item was not a dress but a shirt which the family found in the back of (R32's) closet. During interview 10/20/16, at 10:52 a.m. laundry aide (LA)-A stated that she was aware that R32 had a missing dress, which (R32) had told her about a month ago. She had been looking for it but never found it. The LA-A stated she did not fill out a missing item form but just continued to look for the item herself. During interview 10/20/16, at 11: 00 a.m. LSW stated if items are reported missing they need to be communicating this to her so a missing item form can be filled out and everyone can look for it. The LSW stated she will be re-educating the staff. A facility policy/procedure Missing Items indicated "Any lost or missing item should be immediately reported to staff. Staff will make every effort to assist you in locating the lost or missing item."	F 166	Guidelines were reviewed. All facility staff will be re- educated on the guidelines and process. 4. The Administrator or designee will audit all Feedback Forms received weekly x 1 month and then monthly x2 months to ensure missing items have been addressed and resident/families have received the necessary follow up. Audit results and the data collected will be presented to the QAPI Committee monthly by the administrator or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective Action will be completed by November 25th, 2016	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		11/25/16

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F 225	Continued From page 7 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a background study was completed timely for 1 of 5 employees (E-A) reviewed for abuse prohibition.	F 225	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	

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F 225	Continued From page 8 Findings include: Review of facility new hire prescreening indicated E-A was hired on 08/13/16, but no background check had been completed to determine if this person was not guilty of abusing, neglecting or mistreating residents by law. The facilities Practice Guideline And Procedure VA Policy revision date 12/20/13, indicated under Screening all potential employees will receive a background check. During interview 10/20/16, at 4:13 p.m. E-A stated he was initially hired at the assisted living facility in 2013 and 08/13/16, he transferred to the nursing home as the administrator. The facility had not completed a background check, when he was hired at the nursing home.	F 225	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Employee E-A completed a background study. 2. Employee files were audited to ensure all current employees have completed a background study. 3. Employee File check list was reviewed. VA policy regarding background studies was reviewed. All hiring managers will be re-educated on the Vulnerable Adult policy and hiring process in regards to background studies. 4. Administrator or designed will audit all new hire employee files monthly x2 months to ensure compliance. Audit results and the data collected will be presented to the QAPI Committee monthly by the administrator or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		11/25/16

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F 226	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a abuse policy that directed staff to immediately report to the designated state agency allegations of abuse/neglect or unexplained injury. In addition, the facility failed to implement policies and procedures to ensure background studies were completed timely for 1 of 5 employees (E)-A reviewed for abuse prohibition. Findings include: The facilities Practice Guideline And Procedure VA Policy revision date 12/20/13, indicated Submitting The Report to 1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, place under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident. 3. The Supervisor, Director of Nursing (DON) administrator will immediately institute an internal investigation of the reported allegation or incident. The investigation may include: a. Interviews of staff b. Resident Interviews c. Witness interviews	F 226	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Employee E-A completed a background study. 2. Employee files were audited to ensure all current employees have completed a background study. 3. Employee File check list was reviewed. VA policy was reviewed and adjusted to ensure the process of immediate reporting is understood. All hiring managers will be re-educated on the Vulnerable Adult policy and hiring process in regards to background studies. All facility staff will be re-educated on the VA policy and the process to take when an allegation is made starting with the immediate reporting of the incident. 4. Administrator or designed will audit all new hire employee files monthly x2 months to ensure compliance with background study. Administrator or designee will complete random audits weekly x1 month and then monthly x1 month with staff regarding the VA policy and the steps to take with any	

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F 226	Continued From page 10 d. Environmental review e. Resident health status f. Behavior review g. Medication review The policy directed staff to first investigate the allegation and then make the determination if if should be reported. During interview 10/18/16, at 6:26 p.m. the facility licensed social worker stated if there were any allegations of abuse/neglect or unexplained injury she would first investigate the situation. She would interview staff, resident, and possibly contact the family to make sure she gathered enough information to make a determination if the allegation needed to be reported to the state agency. During interview 10/19/16, at 11:14 a.m. registered nurse (RN)-A stated she had received training on abuse by group orientation and on-line computer training. The RN-A then stated if something is reported to her she would first investigate the situation and then report it to the DON/administrator. Although the facility had no examples of this occurring the policy lacked to indicate the facility must first report the alleged allegation and then conduct the investigation of the allegation, in addition the staff further stated they would investigate first make there determination and then report the allegation of abuse. SCREENING: The facilities Practice Guideline And Procedure	F 226	allegations of abuse/neglect. Audit results and the data collected will be presented to the QAPI Committee monthly by the Administrator or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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F 226	Continued From page 11 VA Policy revision date 12/20/13, indicated under Screening that all potential employees will receive a background check. Review of employee new hire files indicated E-A was hired on 08/13/16, and that no background check had been completed to determine if E-A was not guilty of abusing, neglecting or mistreating residents by law. During interview 10/20/16, at 4:13 p.m. E-A stated he was initially hired at the assisted living facility in 2013. He transferred to the nursing home as the administrator on 08/13/16, and the facility had not completed a background check.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions for toileting were provided for 1 of 1 residents (R31) who was dependant on staff for toileting needs. Findings include: R31 had the diagnoses of Parkinson's, muscle weakness, and dementia without behaviors. The last quarterly Minimum Data Set (MDS), dated	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states	11/25/16

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F 282	Continued From page 12 9/22/16, indicated R31 received extensive assistance from staff for all activities of daily living, and was frequently incontinent of urine. R31's care plan, undated, indicated that R31 had a problem of bladder incontinence which directed staff to offer toileting assistance and check for incontinence upon rise, around meal time, HS (hour of sleep), and at least once nightly including multiple other encounters throughout the day. During continuous observations on 10/19/16, from 6:16 a.m., R31 sat in a room recliner watching, until taken to breakfast at 7:51 a.m.. During this observation toileting was not offered by staff. R31 sat in the dining room eating and people watching from 7:53 a.m., through 9:03 a.m., when NA-A assisted the resident back to the room and placed R31 in the bathroom on the toilet. NA-A removed R31's incontinent pad, and stated (R31) was incontinent of a moderate to large amount of urine. She further described the incontinent product as "heavy" when carrying to the trash can. During interview on 10/19/2016 at 9:05 a.m., NA-A stated she was unaware when R31 was last toileted, (R31) should have been offered to toilet before going to the the dining room and every few hours. NA-A suggested asking the other two NAs working the wing. In an interview at 9:14 a.m., NA-C stated that she had not gotten R31 up for the day and (R31) should be toileted "every two hours." At 9:23 a.m., NA-B, stated the nursing assistant that got R31 up for the day did so around 5:00 a.m. this morning, but was no longer here. NA-B stated R31 was not toileted before	F 282	that: 1. R31 had Continence Evaluation reviewed and updated to reflect any change. NAR Assignment sheet was updated to reflect any change. 2. All residents residing at the facility had Continence Evaluations reviewed and updated as needed to reflect any change. All residents residing at the facility had their toileting care plans reviewed and updated as needed to reflect any change. NAR assignment sheets were reviewed and updated with any changes to residents plan of care. Continence Evaluations, Care Plan updates, and NAR care guide reviews will be completed with each new admission, annually, quarterly, and with a significant change of condition. 3. NAR Care Guideline and Form was reviewed. All Nursing staff will be re-educated on the Care guideline and the use of the care sheets to ensure adherence to residents personal plan of care for toileting needs. 4. DNS or designee will complete random weekly audits x1 month then monthly audits x2 months to ensure staff compliance with resident's plan of care in regards to their toileting schedule. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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F 282	Continued From page 13 going to the dining room, and thought he had already been taken. NA-B stated that R31 was to be toileted "every two hours." Review of the facility Night Shift Work Sheet (dated 10/19/16) identified R31 had been last checked for incontinence of urine at 4:00 a.m. R31 had not been offered toileting assistance from 4:00 a.m. until 9:05 a.m. (5 hours and 5 minutes). During interview on 10/20/2016 at 11:31 a.m., registered nurse (RN)-C stated the resident should be toileted, and not to check and changed including the night shift. RN-C reported staff need to follow the care plan, which was not completed. A facility policy was request but not received.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ongoing consistent monitoring of fluid retention in accordance with physician directed guidelines to prevent complications related to congestive heart failure (CHF) for 1 of 1 resident (R34) who had a	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of	11/25/16

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F 309	Continued From page 14 diagnosis of CHF. This resulted in actual harm for R34, who was hospitalized related to lack of staff monitoring and implementation of the prescribed guidelines. In addition, the facility failed to ensure fluid monitoring was completed as ordered for 3 of 4 additional residents (R61, R46, R44) who required fluid monitoring, and failed to provide proper wheelchair positioning for 1 of 3 residents (R44) who was positioned improperly in her wheelchair. Findings include: R34's admission Minimum Data Set (MDS) dated 9/20/16, indicated the resident had been admitted to the facility on 9/13/16. The MDS further indicated R34 was cognitively intact and had diagnoses including heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), hypertension (high blood pressure) and chronic obstructive pulmonary disease (constriction of the airways and difficulty or discomfort in breathing). R34's Diagnosis Report indicated the heart failure had an onset date of 5/25/11. R34's care plan dated 10/3/16, also indicated R34 had congestive heart failure and directed staff to monitor weights daily and to update the medical doctor (MD) per parameters or facility protocol, to observe/document and report to medical practitioner as needed any signs or symptoms of congestive heart failure, dependent edema of legs and feet, crackles and wheezes, weakness and fatigue. R34's hospital Discharge Summary dated 9/13/16, indicated the resident had experienced an acute seizure, atrial fibrillation (abnormal heart rhythm characterized by rapid irregular beating),	F 309	deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R34 has discharged from the facility R61 has discharged from the facility R46 had fluid restrictions discontinued R44 had fluid restrictions discontinued and was evaluated by Occupational Therapy for wheelchair positioning. 2. Physician Orders for all residents were reviewed for daily weights and fluid restrictions. Residents with orders for daily weights and/or fluid restrictions had Primary MD contacted to verify weight parameters and fluid restrictions. Orders were updated as needed per MD recommendations/orders. All residents residing within the facility utilizing a wheelchair were screened by OT staff for appropriate positioning. 3. System process for daily weight and fluid restriction monitoring were reviewed and adjusted. System for wheelchair positioning screens upon admission, annually, quarterly, and with a significant change was implemented. All nursing staff will be re-educated on the process for monitoring and documenting daily weights and fluid restrictions. All Nursing staff will be re-educated on facility guidelines for Change of Condition and Physician Notification. All facility staff will be educated on the System and process implemented to ensure proper wheelchair positioning. 4. The DNS or designee will complete	

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F 309	Continued From page 15 hyponatremia (low sodium level in the blood) and cardiomegaly (enlarged heart). This hospital Discharge Summary further indicated R34's weight as 187 lbs (pounds). R34's hospital Orders Discharge Report dated 9/13/16, included an order to 'call physician if you gain 3 lbs or more over night, or 5 lbs in a week.' The report further identified R34 as being on a regular diet with a daily fluid restriction of 1000 cubic centimeters (cc). The Sterling Park Health Care Center Medication Review Report dated and signed by the physician 9/13/16, also verified R34 was on a regular diet with 1000 cc fluid restriction and indicated orders to weigh daily, update physician of a 3 pound weight gain over night or 5 pounds in a week. During observation on 10/18/16, at 6:52 p.m. R34 was sitting in her room in a chair with oxygen on per nasal cannula at 2 liters. There was no water pitcher observed in her room. Review of R34's Fluid Monitoring sheet completed by nursing from 9/13/16 to 10/19/16, revealed no documented entries of fluid intake, the sheet was blank, indicating monitoring had not been conducted. During interview on 10/19/16, at 4:38 p.m. licensed practical nurse (LPN)-B confirmed nursing had not been filling out the fluid monitoring sheets according to R34's fluid restriction, however stated dietary staff complete fluid monitoring during meal times. During interview on 10/19/16, at 5:00 p.m. the dietary manager (DM) stated dietary staff had	F 309	audits 3 x week for 1 month and then weekly x2 months to ensure daily weights have been obtained and reviewed and fluid restrictions have been documented and monitored with appropriate and timely notifications given to the MD as needed. The DNS or designee will conduct random monthly audits x2 months on wheelchair positioning screens to ensure timely completion and follow up. Audit results and the data collected will be presented to the QAPI committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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been completing R34's fluid monitoring daily during meal time. The DM also stated nursing was supposed to complete monitoring during non-meal times. The DM provided fluid monitoring sheets from 9/14/16 to 10/01/16, which identified R34's fluid intake during meals ranged from 360 to 1440 cc. The documentation indicated R34 had exceeded her daily 1000 cc fluid restriction seven times during meals. The DM further stated she does not compare nursing and dietary totals to the actual fluid intake for the day and stated she was unsure who was responsible for completing this.

Review of R34's Weights and Vitals Summary form from 9/13/16 to 10/01/16, identified the following:
9/14/16- 197 lbs
9/15/16- 197 lbs
9/16/16- no weight recorded
9/17/16-no weight recorded
9/18/16- 196 lbs
9/19/16- 196 lbs
9/20/16, 9/21/16 and 9/22/16 - no weights recorded
9/23/16- 196 lbs
9/24/16 and 9/25/16 - no weights recorded
9/26/16-204 lbs - 8 lb weight gain in 3 days.
9/27/16- 204 lbs
9/28/16 and 9/29/16- no weights recorded
9/30/16- 205 lbs
10/1/16 admitted to hospital

Although R34 was to be weighed daily, weights were not recorded for 9 out of the 17 days, despite having weight gain of up to 8 lbs identified.

Review of R34's record indicated the following

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F 309	Continued From page 17 communication to her physician: On 9/26/16, a fax was sent (no time) to R34's primary physician which indicated (R34) had complaints of not feeling well. "O2 sats [oxygen saturation in blood, normal saturation 95-100%] 80% on RA [room air]." Two liters of oxygen was administered and saturations ranged from 88-91%. Blood pressure 126/75, pulse 79, respirations 20 and temperature 98.5, which were all in normal range "crackles heard in bilateral lungs." The nurse wrote, "Are you interested in checking any labs or chest x-ray at facility?" There was no physician response identified from this fax communication and the fax did not address R34's 8 lb weight gain. A Progress Note from the facility nurse dated 9/26/16, at 2:31 p.m. indicated, "Left message with MD (medical doctor) to follow up on faxed information sent earlier today. Requested follow up response yet today." There was no indication the physician had responded, nor did the facility document any further communication with the physician about the resident's low oxygen concentration, crackles in her lungs or the 8lb weight gain. A Progress Note dated 9/27/16, at 3:02 p.m. titled Care Conference Review indicated the interdisciplinary team had reviewed the resident's new oxygen use and indicated the MD had been updated with no response yet. The note indicated the resident had been oxygen dependent in the past and does not have needed supplies at home if needed upon discharge. Resident was offered physician appointment and voiced she would feel more comfortable being evaluated by MD. A physician appointment was scheduled for	F 309		

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F 309	Continued From page 18 9/28/16. A St Cloud Medical Group Progress Note documented by a certified nurse practitioner (CNP) dated 9/28/16, included: "R34 presents with one week history of chest pain. These symptoms have been worsening. She has not had a fever or chills." The report further indicated, "Provider did notice that while the O2 tank is new and full, the oxygen was not on. Dial at zero with no flow. Patient states she has been set to two liters, oxygen to be titrated per prior order." The report's Physical Examination note indicated the resident had "non labored breathing, lungs clear, no crackles present, no wheezes present" however, the report did not include a current weight. The report also identified a chest x-ray was completed, had shortness of breath, COPD and was back on oxygen a couple weeks ago. A St. Cloud Medical Group-Center for Diagnostic Imaging-Radiology- X-ray imaging Report date of 9/28/16, identified moderate cardiomegaly with vascular cephalization (pulmonary edema), increased lower lung zone interstitial prominence (tissue and space around the air sacs of the lungs) and new small bilateral pleural effusions (excess fluid built up by the lung). Appearance is concerning for fluid overload/CHF. Pulmonary hyperinflation, as can be seen in the setting of COPD. A handwritten note on the bottom of the fax from the facility to the physician indicated, "Any new orders." The medical record lacked a response from the physician regarding new orders, even though R34 had SOB (shortness of breath), chest discomfort and increased weight. A fax dated 9/30/16 (no time indicated), identified	F 309		

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the "resident's weight today was 205 lbs, and on 9/23/16, was 196 lbs. She continues to need oxygen at two liters to maintain oxygen saturation greater than 90%. Has not been compliant with fluid restriction of 1000 cc/day and met that by lunch yesterday. Currently not on any diuretics." Although the facility fax was sent this was the first notice in the medical record that R34's physician had been notified of the weight gain that had occurred as of 9/26/16 and there was no indication the physician had responded to this fax.

A physician fax sent to the facility on 10/1/16, at 12:35 p.m. indicated, "Send to ER [emergency room] for eval."

A Progress Note dated 10/01/16, at 6:13 p.m. (late entry as a response to 12:35 p.m. fax from physician to send to ER) indicated, "this morning resident had shortness of breath and difficulty breathing, O2 saturations 55% on 3.5 liters of oxygen by nasal cannula, nebulizer treatment administered and O2 saturations increased to 90%. Resident closely monitored during shift. After breakfast with therapist present at bedside resident O2 sat 84% and rechecked again no higher than 77%. The director of nursing (DON) who was present in the building contacted the resident's on call physician and received order to transfer to the hospital."

During interview on 10/19/16, at 4:04 p.m. registered nurse (RN)-B acknowledged they had missing weights for this resident. RN-B stated the nursing staff working with the medication carts are responsible for the daily weights and notification of the weight gain to the physician. RN-B stated she'd been responsible for the medication cart on 9/30/16, had weighed the

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resident, and had sent a fax to the MD notifying him of R34's weight gain.

During telephone interview on 10/19/16, at 4:53 p.m. LPN-D from St. Cloud Medical Group stated R34's physician had responded to the fax he had received on 9/26/16, at 1:17 p.m. He faxed orders to the facility to complete a chest-X-ray, start Lasix (diuretic to remove fluid) 20 mg (milligrams) today and daily for two days and go to ER if worsens. The physician further ordered lab work, CRP (C-reactive protein) an acute phase reactant which is a protein made by the liver and released in blood with in few hours after tissue injury or the start of infection), basic BNP (b-type natiruretic peptide) hormone proceed by your heart response to changes in pressure inside the heart, these changes can be related to heart failure. R34's medical record lacked evidence these orders were received and implemented.

During interview on 10/19/16, at 5:10 p.m. the facility LPN-B, stated they had not received the faxed orders from 9/26/16 even though the clinic indicated they faxed the nursing home. Therefore, R34 had never been placed on Lasix until her hospitalization on 10/1/16.

A Hospitalist History And Physical dated 10/1/16, at 5:34 p.m. indicated R34 had stated she'd "noticed shortness of breath last night and this morning it was fairly severe and was accompanied by chest tightness. She had a productive cough of white sputum, mild fever, no chills, nausea, vomiting or diarrhea. She does not feel that she has gained weight though her discharge weight from 9/13/16, and today's weight showed a 17 pound weight gain. While changing into a hospital gown her oxygen

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saturations dropped to 71%. Patient was given 80 mg (milligrams) of Lasix intravenously, started on BIPAP (bi level positive airway pressure, continues positive airway pressure)." The patient was admitted to the hospital on 10/1/16 and remained there until 10/6/16.

A St. Cloud Hospital Orders Discharge Report dated 10/6/16, indicated R34 had been hospitalized for heart failure, and staff were to weigh daily and report a 3 lbs weight gain or more overnight, or 5 pounds in a week. The orders indicated she was to be weighed daily for consideration of Lasix changes and that she was placed on a 2000 cc fluid restriction and to contact the physician if she had shortness of breath, swelling of feet, decreased exercise tolerance and/or excessive tiredness.

During interview on 10/20/16, at 11:21 a.m. the facility director of nursing (DON) stated on 9/26/16, R34 was noted to have been gaining weight so the nurses faxed her MD but didn't receive a response so the nurses called the MD with still no response. The DON stated the resident had a care conference on 9/27/16, and it was decided to have her seen by her MD with an appointment made for 9/28/16. At the appointment a chest x-ray was ordered, she worsened and was hospitalized. However, the DON was unable to located any documentation in the medical record to verify the physician had been notified of R34's weight gain until 9/30/16, four days after the 8 lb weight gain.

During a telephone interview on 10/20/16, at 11:46 a.m. a St. Cloud Medical Group certified medical assistant (CMA) stated the clinic had faxed orders to the nursing home on 9/26/16.

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The CMA stated that when a fax does not go through, the clinic staff would get a rejection notice and would re-fax the orders. The CMA stated she was unsure why the nursing home would not have received them.

During a telephone interview on 10/20/16, at at 1:28 p.m. R34's primary physician stated he had received the fax from the facility on 9/26/16, and had ordered Lasix, labs, a chest x-ray and to send to the emergency room if worsens. He said he had placed parameters and guidelines in place to prevent hospitalization. Including orders for the facility to monitor weights, fluid intake, and to notify him if there was a weight gain. The physician stated he signed the orders on 9/26/16, at 1:17 p.m. and faxed it back to the nursing home. He was not certain why they did not receive them. The physician said, if the nursing home had not heard back they should have called again and stated "If faxes were not working calling is always an option."

During interview on 10/21/16, at 9:12 a.m. the facility's director of nursing (DON) stated she was aware of the concerns with the nursing staff and the need to use judgement when to fax and when to call a physician. The DON stated she would be implementing a system so this issue would not occur again.

Even though R34 had physician orders to monitor daily fluid intake, daily weights and parameters of when to contact the physician. The facility failed to consistently monitor R34 for these parameters, and notify the physician when R32 had decreased oxygen saturations which required supplemental oxygen, changes in her respiratory status and a weight gain of 8 lbs. As a result of inconsistent

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monitoring and inadequate physician notification and follow up, R34 experienced actual harm and was hospitalized 5 days for heart failure.

A facility Change In Condition When To Report To The MD/NP/PA undated indicated to report to them immediately of weight gain associated with respiratory symptoms, weight gain or >3 lb. in one day or 5 lb. in one week. The report further indicated to notify of abrupt onset of shortness of breath with pain, fever or respiratory distress.

LACK OF FLUID RESTRICTION MONITORING:

R61's Inpatient Discharge Summary dated 10/11/16, identified R61 had stage IV chronic kidney disease and diastolic congestive heart failure. R61 had been scheduled for surgery during hospitalization, however it had been postponed due to, "Deteriorated" kidney function and hemodialysis was started, "Shortly after." Further, the summary identified R61 to have a dialysis diet ordered with a 1500 ml (milliliter) fluid restriction. A subsequent physician order dated 10/17/16, identified R61's fluid restriction had been changed to 2000 ml per day.

During observation on 10/18/16, at 4:57 p.m. R61's room had a blue water pitcher and small glass of red colored juice on the bedside table. The water pitcher was untouched, however the glass of red juice was only half full.

During subsequent observation on 10/19/16, at 1:19 p.m. R61 was seated in her room visiting with her family. R61 had been served a lunch meal along with two 240 cc glasses of red colored juice, and two coffee cups with light brown colored fluid inside. R61 had consumed over

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50% of three of the four provided cups of fluids. R61 stated she was unaware of any fluid restrictions in place for her diet adding staff wanted her to drink as much fluid as possible, "[They] try to get me to push fluid because of the kidney."

When interviewed on 10/19/16, at 2:15 p.m. nursing assistant (NA)-A stated R61, "Usually eats in her room," adding she was unaware if R61 had any restrictions on her diet or fluid intake, "I honestly am not sure." NA-A stated the staff member removing R61's meal tray from her room should be recording the fluid intake on a flowsheet kept by Dietary though, "At the end of every meal."

R61's untitled dietary flowsheets dated 10/13/16, through 10/18/16, identified R61's name and three separate columns to record each of the three meal's fluid intakes. However, only six entries were completed with fluid intake being recorded for the six day period. The remainder of the spaces provided to document the fluid intake were either left blank, or had, "RT [room tray]" written in them.

During interview on 10/19/16, at 2:19 p.m. NA-E stated R61 eats, "In her room most of the time," and meal and fluid intakes were recorded, "In the computer." NA-E stated he thought R61 had a fluid restriction in place, but added he was unsure, "The nurse should know." NA-E stated any residents on fluid restrictions should not have water mugs placed in their rooms. NA-E and the surveyor observed R61's room at 2:24 p.m. with a blue water pitcher on the bedside table. NA-E stated R61 should not have had a water pitcher placed in her room adding there was, "Not much

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in there [water]." Further, NA-E stated the water consumed by residents in the bedside pitchers was not tracked to his knowledge.

R61's untitled flowsheet dated 10/16, identified R61 had a 1500 ml fluid restriction in place with, "2000 ml restriction" being written along the side of the form on 10/17/16. The form had each day of the month with times written to cover a 24 hour period including a, "24h [24 hour] total," row at the bottom. However, R61 had only one entry completed on the flowsheet which identified she had consumed 400 ml of fluid on 10/14/16 at 0800. The remainder of the flowsheet was left blank, and no 24 hour totals were identified.

When interviewed on 10/19/16, at 2:25 p.m. licensed practical nurse (LPN)-E stated R61 was, "Newer" to dialysis and staff were monitoring her fluids and meal intakes, "As best we can." LPN-E stated nursing staff was responsible to track R61's fluid intakes on flowsheets kept in the Medication Administration Record (MAR) adding if R61 had too much fluid intake it could cause edema in her legs or crackles in her lungs with, "Troubles with breathing." Further, LPN-E reviewed R61's fluid intake flowsheet and stated it should be filled in and completed to monitor how much fluid she was taking in, "We need to educate staff on keeping track of that."

During interview on 10/19/16, at 3:47 p.m. registered nurse (RN)-A stated R61 started dialysis when she was hospitalized in the beginning of October 2016 and admitted to the facility on a 1500 ml fluid restriction. RN-A stated R61's physician increased the restriction to 2000 ml shortly after admission, and staff were expected to monitor R61's fluid intake on the

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flowsheet(s) in the MAR. Further, RN-A reviewed the flowsheets with only a single entry recorded and stated staff should have completed the intake monitoring because too much fluid, "Could cause fluid overload."

When interviewed on 10/19/16, at 4:03 p.m. the dialysis registered dietician (RD)-A stated staff should be monitoring R61's fluid intake in order to provide, "A general idea on how much fluid they [R61] are consuming." RD-A stated fluid monitoring was important for a dialysis patient as it, "Helps us discern if the patient is actually gaining fluid weight or body weight," and ensure R61 was being, "Dialyzed correctly." Further, RD-A stated a lack of monitoring on a new dialysis patient could cause, "Issues with volume overload and shortness of breath," and she expected the facility to monitor R61's fluid intake, "It's an ongoing thing."

A facility Dialysis Audit policy dated 5/2015, identified, "All resident's [sic] receiving dialysis services will have appropriate nursing interventions in place assure optimal care/outcomes." Further, the policy directed the physician orders should specify any diet or fluid restrictions and staff were to record intakes on the treatment records.

R46's 60-Day Minimum Data Set (MDS) dated 9/15/16, identified R46 had severe cognitive impairment and received a therapeutic diet.

R46's Internal Medicine progress note dated 9/21/16, identified R46 had been seen by the physician for, "Followup on her sodium," as she, "Does have hyponatremia [low sodium levels]."

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R46's attached laboratory results identified her sodium level to be 138 mm/L (millimoles per liter) which is toward the low end of the identified reference range (136-146 mmol/L).

R46's signed physician orders dated 10/14/16, identified R46 to be on a, "1500 cc [cubic centimeter] fluid restriction."

During observation on 10/20/16, at 12:06 p.m. R46 was seated in her recliner chair in her room. R46 had a small bedside table to her left side which had a blue water mug sitting on top. R46 stated the staff, "Bring a new one in the morning and at night," for her to drink. The water mug was picked up by the surveyor and was approximately 50% full. R46 stated she drank some water already that day adding, "I should drink more than I do." Further, R46 stated she did not think she was on any fluid restriction from the physician.

On 10/20/16, at 12:11 p.m. nursing assistant (NA)-C observed the blue water mug on R46's bedside table and stated she should not have one given to her because she was on a fluid restriction.

When interviewed on 10/20/16, at 2:46 p.m. registered nurse (RN)-B stated R46 was on a, "1500 cc fluid restriction," for her low sodium levels.

R46's Medication Administration Record (MAR) was reviewed. The MAR contained an untitled flowsheet dated 9/2016, with a spacing labeled, "Fluid Order:," with hand written, "1500 ml [milliliters]," being identified. The form had each day of the month with times written to cover a 24

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hour period including a, "24h [24 hour] total," row at the bottom. However, R46 had only three entries completed on the flowsheet which identified she had consumed 60, 100 and 180 cc's of fluid on three separate days. The remainder of the flowsheet was left blank, and no 24 hour totals were identified.

During interview on 10/20/16, at 2:57 p.m. the certified dietary manager (CDM)-A stated dietary was responsible to record the fluid consumed at meals for residents, however not for the fluids consumed in the room or outside of meal times, "My understanding was that it was nursing [responsible]." Further, CDM-A stated nursing should be tracking and totaling all of R46's fluids in a 24 hour period to ensure she did not breach her ordered restriction. \

When interviewed on 10/20/16, at 3:29 p.m. RN-B stated R46's fluid restriction was not being monitored consistently, "There is some lacking documentation." RN-B stated the night shift nurse should be totaling the fluids consumed and recording it on the flowsheet to ensure R46's fluid restriction was not breached and help, "Keep her sodium levels regular."

R44's quarterly Minimum Data Set (MDS) dated 8/25/16, identified R44 had intact cognition and received a therapeutic diet.

R44's Inpatient Discharge Summary dated 6/3/16, identified R44 had been hospitalized for, "Acute on chronic systolic congestive heart failure exacerbation," and several discharge orders which included a 2000 ml (milliliter) fluid restriction.

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R44's care plan dated 6/6/16, identified R44 had a, "Potential nutritional problem" and directed staff to, "Provide, serve diet as ordered ... 2000 cc fluid restriction present." Further, the care plan directed staff, "Offer snack and fluid b/w [between] meals per coffee socials, snack carts, water pitcher at bed side and with med pass."

R44's physician order fax dated 8/4/16, identified orders for R44 which included, "1500 cc [cubic centimeters] fluid restriction," and, "Recheck sodium in 1 month."

R44's progress notes dated 10/14/16, identified R44 had a weight gain which, "Appears to be r/t increased fluid balance." Further, the note identified this concern had been, "Discussed" with nursing and orders were in place, "To monitor fluid balance."

During observation on 10/20/16, at 10:54 a.m. R44 was seated in her room next to her bedside table. R44 had a 1/2 full cup of coffee and a blue colored water mug on her bedside table which was approximately 50% full.

When interviewed on 10/20/16, at 10:55 a.m. nursing assistant (NA)-C stated R44 was, "Independent" with eating and drinking and was currently on a fluid restriction so staff don't, "Put anything in her room," for her to drink. NA-C observed R44's bedside table with a water mug and cup of coffee and stated she, "Didn't notice it before" the surveyor had pointed it out adding the previous shift, "Probably overlooked that." NA-C stated was not supposed to have a water mug in her room. Further, NA-C stated the nursing staff was responsible to record meal intakes for R44,

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but Dietary was responsible to record her fluid intake for meals.

R44's untitled dietary flowsheets dated 10/6/16, through 10/19/16, identified R61's name and three separate columns to record each of the three meal's fluid intakes. R44's meal fluid intake ranged from a total of 250 ml to 1130 ml of according to the flowsheets, however there was no recorded information to identify the amount of fluids consumed from the bedside containers.

During interview on 10/20/16, at 11:01 a.m. licensed practical nurse (LPN)-C stated she was unaware R44 had current orders for a fluid restriction. LPN-C stated R44 had, "Really bad" edema (swelling of the legs caused by fluid) and were, "Weeping really bad," when R44 first admitted to the nursing home adding R44 had current orders for Lasix (a diuretic medication). LPN-C stated nursing staff was not tracking any of R44's consumed fluids, including the water and fluids provided at her bedside, to ensure she did not breach her restriction adding, "It would have been nice to know."

When interviewed on 10/20/16, at 11:08 a.m. registered nurse (RN)-B stated R44 had been on a fluid restriction since coming from the hospital for an exacerbation of her heart failure in June 2016 adding staff, "Are supposed to monitor their fluid intake." RN-B stated nursing staff should have placed a tracking sheet in R44's Medication Administration Record (MAR) to track her total fluids for meals, medication pass and bedside intake as, "That's the only system we have that I know of," to ensure fluid restrictions were not breached. Further, RN-B stated R44 should not have bedside water mugs placed in her room and

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nursing should have been tracking her total fluid intake, "So that we don't exacerbate their current medical conditions."

R44's Medication Administration Record (MAR) was reviewed and lacked any flowsheets or tracking devices to monitor and record R44's fluid intake.

When interviewed on 10/20/16, at 3:50 p.m. the director of nursing (DON) stated she was aware fluid restrictions weren't being monitored adding, "They [staff] have nobody right now," who is responsible to ensure it was completed. Further, the DON stated the dietary and nursing staff should be coordinating to ensure all fluid intake was monitored, "There's not a system in place at the current time to do that."

A facility policy on fluid monitoring was requested, but none was provided.

LACK OF PROPER WHEELCHAIR POSITIONING:

R44's quarterly Minimum Data Set (MDS) dated 8/25/16, identified R44 had intact cognition and used a wheelchair for mobility.

During observation on 10/17/16, at 2:30 p.m. R44 was seated in her room in a standard wheelchair. Her buttocks was positioned towards the front of the seat portion of the chair causing her to lean back with her head on the left handle. R44 had a one-half circle shaped cushion placed behind her in the chair, however her buttocks was seated so far forward it caused her back to not contact the cushion while seated in the chair.

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F 309	Continued From page 32 During additional observation on 10/19/16, at 10:18 a.m. R44 was seated in her room in the same standard sized wheelchair. R44 continued to have her buttocks positioned toward the front of the cushion and her head resting on the left handle of the wheelchair causing her to appear reclined in the standard wheelchair. On 10/19/16, at 10:21 a.m. nursing assistant (NA)-A observed R44 seated in her standard wheelchair with the surveyor. NA-C stated R44 appeared, "A little uncomfortable" in her wheelchair adding her head appeared, "Kinda tilted back," and, "Was not upright." NA-A she had noticed R44 to have poor positioning in her wheelchair before even being seen to, "Sleep in the dining room like that." NA-A stated she had not reported these positioning concerns to nurses as, "They see just as much as I would." Further, NA-A stated she was unaware if therapy had ever worked with R44 on her wheelchair positioning. On 10/19/16, at 10:47 a.m. registered nurse (RN)-B observed R44 seated in her standard wheelchair and stated she, "Doesn't look like she's very comfortably positioned." RN-B stated occupational therapy (OT) had worked with R44 for wheelchair positioning in the past, however was not currently seeing her for any positioning concerns. Further, RN-B stated R44 should be seated upright in the wheelchair for her comfort and to reduce her risk of skin breakdown, "Those are the main things we look for." R44's Occupational Therapy Plan of Care dated 7/17/15, identified R44 had, "Difficulty with positioning in w/c [wheelchair] which puts her at risk of falling," and listed a goal of, "Will sit	F 309		

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F 309	Continued From page 33 symmetrically in wheelchair and have reduced skin breakdown/pressure areas and falls..." Further, R44's Therapist Progress & Updated Plan of Care dated 8/13/15, identified R44 required, "Contact guard assist to sit symmetrically in wheelchair in order to safely sit upright with hips back in w/c." During subsequent interview on 10/19/16, at 12:29 p.m. RN-B stated R44 had not been referred to OT since October 2015, for her wheelchair positioning because staff had not reported it as a concern. RN-B stated she expected staff to report observed positioning concerns to her so she could of, "Requested an order for OT to see her again." The OT responsible for R44's care was not available for interview during the survey. A facility wheelchair positioning policy was requested, but none was provided.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		11/25/16

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F 315	Continued From page 34 by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide medical justification for the continued use of an indwelling catheter for 1 of 2 residents (R42) reviewed for urinary catheter use. Furthermore, the facility failed to ensure that required assistance with incontinence care was provided for 1 if 1 residents (R31) who was dependant upon staff for toileting needs. Findings include: LACK OF JUSTIFICATION FOR CATHETER: R42's admission Minimum Data Set (MDS) dated 9/30/16, identified R42 was cognitively intact, used an indwelling catheter, a trial voiding program had never been attempted. The MDS also identified R42 required extensive assistance with toileting. R42's Care Area Assessment (CAA) dated 10/5/16, indicated R42 had urinary urgency and needed assistance with toileting, and had an indwelling catheter due to limited mobility and comfort. R42 was receiving hospice services and was non-weight bearing making toileting very difficult and painful. R42's care plan dated 10/12/16, indicated R42 had an indwelling catheter related to hip fracture with non-weight bearing status and comfort cares. The care plan also identified movement for toileting caused significant pain for R42. During observation on 10/18/16, at 4:07 p.m. R42 was lying in bed with catheter bag attached to the side of her bed. R42 stated she did not have any	F 315	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R42 expired R31 had Continence Evaluation reviewed and updated as needed. NAR care guide was updated to reflect any changes to toileting needs. 2. No other residents in the facility have a catheter. All residents residing in the facility had their Continence Evaluations reviewed and updated as needed to reflect any change. All residents had their toileting care plans reviewed and updated as needed with any changes. NAR Care Guides were updated to reflect any changes made with toileting schedules or continence concerns. Continence Evaluations, Care Plan updates, and NAR care guide reviews will be completed with each new admission, annually, quarterly, and with a significant change of condition. 3. NAR Care Guideline and Form was reviewed. All Nursing staff will be re-educated on the Care guideline and the use of the care sheet to ensure adherence to residents personal plan of care for toileting needs. All nursing staff	

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F 315	Continued From page 35 pain or discomfort, and denied having pain without relief. During subsequent observation on 10/19/16, at 12:52 p.m. R42 was lying in her bed with the head of the bed slightly elevated. R42 did not appear to be in any pain or discomfort. When interviewed on 10/19/16, at 1:06 p.m. registered nurse (RN)-B stated R42 was admitted to the facility with an indwelling catheter on 9/24/16. The resident had an indwelling catheter due to a hip fracture, pain, and bed rest, however; RN-B added, R42's pain had been better controlled. The facility had never attempted to remove R42's catheter to determine if she could void without the catheter after they addressed her pain. During interview on 10/21/16, at 8:21 a.m. the director of nursing (DON) stated R42 had the catheter placed prior to admission to the facility after she fractured her hip. DON added, R42 had intractable pain, but the DON could not locate a diagnosis for intractable pain for R42. Although the resident had an indwelling catheter, the facility had not attempted any removal of the urinary catheter even though R42 pain was in control. LACK OF TOILETING: R31 had the diagnoses of Parkinson's, muscle weakness, and dementia without behaviors, identified in the undated care plan. The quarterly minimum data set (MDS), dated 9/22/16, indicated R31 received extensive assistance from staff for all activities of daily living, and was	F 315	will be re-educated on the requirements for Catheter use including obtaining an appropriate diagnosis and documentation/orders for its use. 4. DNS or designee will complete random weekly audits x1 month then monthly audits x2 months to ensure staff compliance with residents plan of care in regards to their toileting schedule. Residents newly admitted with a catheter or with new catheter orders will be audited within 48 hours to ensure appropriate diagnosis and documentation are in place. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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frequently incontinent of urine. The last Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter (dated 6/24/16), indicted that R31 had urge incontinence , Flomax (medication used to help control bladder function) was discontinued with no changes in bladder dysfunction and needed staff assistance for toileting. The CAA indicated that R31 would be toileted "upon rising, around meals, HS [hour of sleep], and once nightly."

During continuous observations on 10/19/16, from 6:16 a.m., R31 sat in a room recliner watching television, until staff brought him to breakfast at 7:51 a.m. R31 was not offered to be toileted by staff during this time.

R31 sat in the dining room eating and people watching from 7:53 a.m., through 9:03 a.m., when NA-A assisted the resident back to the room and placed him on the toilet, and voided. NA-A removed R31's incontinent pad, and stated (R31) was incontinent of a moderate to large amount of urine.

During interview on 10/19/2016 at 9:05 a.m., NA-A stated she was unaware when R31 was last toileted, (R31) should have been offered to toilet before going to the the dining room and every few hours. NA-A suggested asking the two other NAs working the wing. In an interview at 9:14 a.m., NA-C stated that she had not gotten R31 up for the day and he should be toileted "every two hours." At 9:23 a.m., NA-B, stated the nursing assistant that got R31 up for the day did so around 5:00 a.m. this morning, but was no longer here. NA-B stated R31 was not toileted before going to the dining room, and thought he had

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already been taken by another nursing assistant. NA-B stated (R31) should be toileted "every two hours."

Review of the facility Night Shift Work Sheet (dated 10/19/16) identified R31 had been last checked for incontinence of urine at 4:00 a.m. R31 had not been offered toileting assistance from 4:00 a.m. until 9:05 a.m. (5 hours and 5 minutes).

R31 last Continence Evaluation, dated 9/22/16, indicted R31 had incontinence issues of bladder related to cognitive ability associated with Parkinson's disease. R31 had been on Flomax but there was no change and was discontinued. The assessment further indicate R31"has been waiting for staff assist with toileting. Currently staff are offering toilet reminders/assist at regular intervals (upon rise, around mealtimes, HS, and once nightly.) [R31] has stated satisfaction with this plan. Will care plan to continue to provide assist with toileting at routine intervals. No changes for this review."

In review of the Nursing Assistant Care Plan sheet (updated 10/20/2016), this sheet further indicated that R31 was dependant on facility staff for toileting needs, and was to be toileted "upon rise, around meal times, HS, once nightly and PRN (as needed)."

During interview on 10/20/2016 at 11:31 a.m., registered nurse (RN)-C stated sometime (R31) refuses to be toileted either before of after meals. RN-C stated their expectation that staff follow the care plan, and toilet him not just to check and change his incontinent product.

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F 315	Continued From page 38 A facility policy was request but not provided.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, analyze, and identify trends to reduce the risks of falls for 1 of 3 residents (R38) reviewed for accidents. Findings include: R38's annual Minimum Data Set (MDS), dated 10/6/16, indicated R38 had dementia with Lewy Bodies (a progressive degenerative disease or syndrome of the brain) and Parkinson's disease (a progressive disorder of the nervous system that affects movement) with moderate cognitive impairment, required limited assistance of one for transfers, and had multiple falls. R38's Fall Care Area Assessment (CAA) Worksheet, dated 10/11/16, indicated R38 had Parkinson's with associated altered gait, bilateral lower extremity edema, and a history of falls. The CAA also indicated R38 had three falls since his previous assessment.	F 323	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Regarding R38- Interdisciplinary Team members met with Primary MD to discuss residents fall history and current status. Facilities review and findings of fall history are incongruent with that of MDH. Facility finds no significant trends or patterns as to when falls occur. MD made medication adjustments including the addition of diuretics for a newly suspected diagnosis of CHF. R38's falls will continue to undergo Interdisciplinary	11/25/16

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F 323	Continued From page 39 R38's care plan dated 10/18/16, indicated R38 was at risk for falls related to a history of falls prior to admit, Parkinson's with associated altered gait, lower extremity edema, progressive decline in functional status, daily diuretic (medication used to increase urine excretion), and daily anti-Parkinson's medication. The care plan indicated several interventions for reducing R38's falls including assist of one for transfers and ambulation, call light within reach, anti-roll back on wheelchair, encourage non-pharmacological interventions to promote sleep such as television, snacks, etc., occasionally will nap during the day, Remeron (an antidepressant used to treat major depressive disorder) to improve sleep, resident not left in bathroom, review information on past falls and attempt to determine cause of falls and document, offer toileting if noted to be awake at night and around midnight rounds and 4:00 a.m. rounds. The care plan goal for R38 was to be free of falls. During observation on 10/18/16, at 4:44 p.m. R38 was sitting in his wheelchair in the dining room looking out the window. A few minutes later, R38 began propelling himself with his feet across the dining room in his wheelchair. During observation on 10/18/16, at 6:46 p.m. R38 was sitting in his wheelchair in the dayroom. R38 stood up from his wheelchair and started walking down the hall. The administrator immediately went to R38 and assisted him by walking with R38 until an unidentified staff member brought R38's wheelchair to him. During observation on 10/19/16, at 6:12 a.m. R38 was awake sitting in his recliner in his room watching television and was already dressed for	F 323	Team Review and analysis after each occurrence. 2. All residents residing within the facility have had their Morse Fall Scale reviewed and updated as needed. All resident fall care plans were reviewed and updated. NAR Care guides have been updated to reflect current fall interventions. Morse Fall Scale, Care Plan updates, and NAR care guide reviews will be completed with each new admission, annually, quarterly, and with a significant change of condition. 3. Interdisciplinary Team Meeting Guidelines regarding fall management were reviewed. Post Fall guidelines were reviewed. Post Fall Analysis documentation record was implemented for Interdisciplinary Team use to ensure analysis of residents fall history was included with Interdisciplinary Team analysis of current fall. All nursing staff will be re-educated on Interdisciplinary Team Guidelines regarding falls, Fall Guidelines and Documentation, and new Post Fall Analysis documentation. 4. Administrator and/or DNS will complete weekly audits x1 month then monthly audits x2 months to ensure documentation and post fall analysis has been completed with each fall. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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the day. His call light was near his left hand. His bed was made and his blinds were closed.

During observation on 10/20/16, at 8:53 a.m. R38 was on the Nu-Step exercise machine. No staff were present at this time.

During interview on 10/21/16, at 10:33 a.m. R38 stated, "I am tired today." R38 was noted to be yawning several times while surveyor was visiting with him.

Review of the facility notes identified the following:

A facility Incident Note, dated 12/10/15, at 2:40 p.m. indicated R38 was found on the floor. He was not wearing any pants, shoes, or a brief. The nursing assistant reported R38's foot was entangled in a cord from his phone. The note indicated immediate interventions of moving his phone to end table, de-cluttered cords, and instructed R38 to make phone calls from his wheelchair and not to move his phone.

A subsequent Incident Note, dated 2/15/16, at 10:53 a.m. indicated per video, R38 had ambulated in hallway with walker, bumped into a wall with the walker and was unable to move the walker. R38 lowered himself to his knees and was able to stand up again independently. The note indicated an immediate intervention of, "requesting PT [physical therapy]."

A subsequent Incident Note, dated 3/8/16, at 10:53 a.m. indicated R38 was found on the floor in the bathroom. R38 stated he slipped on the floor and fell down, urine noted on the floor in bathroom. The note indicated an immediate

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intervention that R38 to not to be left alone on the toilet.

A subsequent Incident Note, dated 3/19/16, at 1:20 a.m. indicated R38 was found on the floor of dayroom on his back at around 9:00 p.m. on 3/18/16. R38 stated that he, "just wanted to lay down here for a while." Resident stated he did not fall. The note indicated R38 was educated on importance of asking for help to bed or to ambulate and keep close watch on R38 throughout shift.

A Resident Incident Report, dated 4/20/16, at 9:00 p.m. indicated nursing assistant found R38 using a wheelchair as a walker and exiting the dining room near the front entrance. R38 was bleeding from left eyebrow and obtained a one centimeter (cm) cut. R38 stated, "I just fell, that's all" when asked. Initially stated he was walking, but upon inquiry about whether he was using a device he stated, "I don't know what happened." The Resident Incident Report indicated an intervention to update MD [Medical Doctor] on lack of sleep to request pharmacological intervention.

R38's Incident Note, dated 4/25/16, at 7:50 a.m., indicated at 11:40 p.m. on 4/24/16, R38 was found in his room kneeling on one leg with the other leg up and hands stretched towards the bed. R38 could not identify what happened. The note indicated an intervention/suggestion to make sure staff were watching him at all times.

A subsequent Incident Note, dated 5/20/16, at 11:56 p.m. indicated a nursing assistant found R38 lying on the floor in his room. He was laying face up with his knees bent between chair and

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bed. R38 claimed he moved himself to the floor so could do his exercises. The note indicated they explained to R38 the proper use of call light and he does not need to exercise at this time. Educated on importance of allowing staff to help transfer in order to avoid further falling.

A subsequent Incident Note, dated 7/19/16, at 2:21 a.m. indicated R38 had just finished his "exercises" (squats with use of grab bar) and staff attempted to assist R38 back to his chair; however, R38 was refusing assistance. R38 was shuffling, lost his balance and lowered self to his knees with his hands on his chair. The note indicated interventions of discussing removing grab bar as resident does not utilize it for its intended purpose.

A subsequent Incident Note, dated 9/30/16, at 4:30 p.m. indicated R38 was ambulating without assistance when he lost his balance and fell forward. He landed on his elbows and knees. The note indicated an intervention to request referral for PT/OT (physical therapy/occupational therapy).

A subsequent Incident Note, dated 10/2/16, at 3:12 p.m. indicated R38 was sitting in his wheelchair in the dayroom when he suddenly rose from his chair and ran/shuffled toward the main door. He lost his balance, fell forward and caught himself on a table, but was unable to maintain his balance. The note indicated interventions were to contact Dr. Watkins for PT/OT orders.

A Resident Incident Report, dated 10/10/16, at 2:10 p.m. indicated R38 had two cups of bingo chips in his hands. R38 got up from his

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wheelchair and as he was attempting to walk to the bingo table, R38 started to shuffle his feet, he froze and fell on his knees. The Resident Incident Report included interventions to continue PT as prescribed and educated resident on importance of safety.

A Resident Incident Report, dated 10/18/16, at 1:15 a.m. indicated staff heard a loud noise, went from room to room to check on residents and found R38 on his bathroom floor with his back positioned to the bathroom door. R38 was sitting on his bottom in an upward position. Resident Incident Report included interventions to toilet at night when awake, post void residuals for three days, orthostatic (upright posture) blood pressures every shift for three days, and to ambulate with staff to meals.

Although the facility reviewed each fall for R38 and had discussed them in interdisciplinary team meetings (IDT), implemented several interventions, R38's falls were not comprehensively assessed, tracked, trended, or analyzed to identify the 12 falls R38 had since December 2015. Four of the 12 falls occurred between the hours of 2:10 p.m. and 4:30 p.m. and six of the 12 falls occurred between the hours of 9:00 p.m. and 2:21 a.m.

When interviewed on 10/19/16, at 6:18 a.m. nursing assistant (NA)-B stated he worked the night shift. NA-B stated R38 got up on his own a lot, and added, R38 does not have trouble getting up, but R38 had a hard time with his balance once he is up, "Balance is his issue."

During interview on 10/19/16, at 7:25 a.m. NA-C stated R38 typically sat in his wheelchair and

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propelled himself around. NA-C stated she was not aware of any patterns to R38's falls.

When interviewed on 10/19/16, at 7:37 a.m. licensed practical nurse (LPN)-E stated R38 was, "Unstable on his feet" and had a habit of standing on his own. LPN-E added R38 did not spend very much time in his room.

During interview on 10/19/16, at 8:27 a.m. LPN-A stated R38 was instructed to wear compression stockings, but he often removed them, which could have been a contributing factor to R38's falls due to swelling which may have caused issues with R38's circulation and blood pressure. LPN-A stated there has been, "No patterns noted with his falls."

When interviewed on 10/20/16, at 10:22 a.m. registered nurse (RN)-A stated, "I think we are doing everything we can to help prevent future falls for [R38]." RN-A further stated if R38's falls continued, staff would talk with R38 and his family to see if a different location, or an alternative placement would be better for R38.

When interviewed on 10/21/16, at 10:37 a.m. NA-D stated his work shift usually started at 6:00 a.m. and most days when he arrived to work at 6:00 a.m., R38 was already up and and sitting in the day room. NA-D described R38's usual daily routine to include getting up before 6:00 a.m., traveling around in the hall and day room throughout the morning until breakfast. After R38 finished his breakfast, R38 would go to the Nu-Step exercise machine for approximately 10-20 minutes and then R38 would travel back to his room to use the bathroom where staff would toilet him. After toileting, R38 would "tootle"

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around around again until lunchtime. After lunch, R38 would usually go to his room or sit in the dayroom. NA-D added, "I never see him nap in bed," but R38 often sat with his eyes closed. NA-D stated, "He doesn't take a good nap during my shift."

During interview on 10/21/16, at 10:57 a.m. physical therapist (PT) stated R38 would probably benefit from a restorative program and a structured sleep routine. PT also stated we need to try different things with R38.

When interviewed on 10/21/16, at 1:03 p.m. NA-F stated she worked all the different shifts at the facility. NA-F stated R38 usually only slept for a few hours at a time and was usually awake off and on all night. In addition, NA-F stated R38 typically was up by 4:00 a.m. everyday.

During interview on 10/21/16, at 1:19 p.m. RN-A stated staff discussed resident falls at weekly fall meetings by reviewing the falls and looking for patterns or trends in general, but not for R38. RN-A stated R38's normal sleep was in his recliner in his room, not in his bed. We have not trended his falls in regards to timeline or with time of day. In addition, RN-A added, we have not looked at R38 for trends or patterns of his falls to determine what could possible help keep him safe, like a nap in the afternoon or a rehabilitation program. She stated she had not made the connection of R38 getting up early at 4:00 a.m. not adequately resting, which may be a factor to his falls.

When interviewed on 10/21/16, at 1:49 p.m. the director of nursing (DON) stated I have only been here a week and falls immediately flagged my

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F 323	Continued From page 46 attention. We do have data collection for falls, we have a system for tracking and trending falls and for looking for patterns for falls, but the data has not been analyzed. DON added, we do have a good system, but the system has not been utilized the way it should. Although R38 was up early, had a non-sleep pattern at night and did not take naps, the facility had not comprehensively reassessed R38's falls to determine a pattern of falls in the mid to later afternoon and between 9:00 p.m. and 2:21 a.m. The facility did not implement interventions during these timeframe's to help decrease R38's risk for falls. A facility Fall Risk and Fall Prevention Guideline, dated 10/13, indicated, "The DNS [director of nursing service] and/or designee is responsible for monitoring falls for patterns of time, locations and activity to determine appropriate staffing levels and necessary supervision."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		11/25/16

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(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
F 325	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess nutritional status to prevent potential weight loss for 1 of 3 residents (R46) reviewed for nutrition. Findings include: R46's 60-Day Minimum Data Set (MDS) dated 9/15/16, identified R46 admitted on 7/21/16, had severe cognitive impairment, and required supervision with eating. Further, the MDS identified R46 weighed 101 pounds and was 60 inches tall. An Imperial Body Mass Index (BMI) calculation of R46's height and weight obtained from the MDS identified R46 had a BMI of 19.7, and R46's signed Medication Review Report dated 10/14/16, identified she had no nutritional supplements ordered. During observation on 10/18/16, at 5:57 p.m. R46 was seated a table in the main dining room with several other residents. R46 was served a bowl of beef stew, breadstick, vegetable mix (celery sticks, carrots and cucumbers) with a cookie on a regular plate. R46 was assisted with eating by nursing assistant (NA)-G at times throughout the meal. At 6:35 p.m. NA-H approached R46 who had put her napkin down on the table, "[R46] are you ready to go?" R46 was assisted out of the dining room having consumed 100% of the provided beef stew and 75% of the breadstick. The provided cookie and vegetables were untouched on R46's plate, and no nutritional supplements were served during the meal.	F 325	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R46 had Nutritional Assessment completed. 2. Weight history report was pulled for all residents residing within the facility. Any resident that had triggered for a weight loss of 5% in 30 days or 10% in 160 days had a Comprehensive Nutritional Assessment completed. Nutritional Assessments will be completed with each new admission, annually, quarterly, and with a significant change of condition. 3. Nutritional Guideline was reviewed. Re-education was provided to Dietary Manager regarding Nutritional Guideline policy and procedure to ensure completion of nutritional assessments per facility policy. 4. DNS or designee will complete random audits weekly x1 month and then monthly x2 months to ensure completion of Nutritional Assessment per facility guidelines. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI	

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 _____	10/21/2016

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F 325	Continued From page 48 When interviewed on 10/18/16, at 7:24 p.m. R46 stated she enjoyed the meal served to her, however she did not enjoy celery and was still being served it at times. R46 stated her weight had fallen from 120 pounds, "A couple years ago." R46 stated nobody from the facility had ever visited with her about her nutrition or weight, "Not really," adding she would be willing to consider starting a nutritional supplement if it had been offered, "I'd think about it." R46's undated Nutritional Status Care Area Assessment (CAA) identified R46 had a, "Potential" problem with her nutritional status, and would be addressed in her care plan adding, "Weight remains stable at this time." The CAA did not identify R46's current eating pattern(s), communication barriers, dental concerns, medication consumption, or any environmental factors which could impact her nutritional status. These areas were left blank on the CAA. R46's medical record was reviewed and lacked any comprehensive nutritional assessment to ensure R46's weight was improved and/or maintained. When interviewed on 10/20/16, at 2:46 p.m. registered nurse (RN)-B stated R46 had lived at the facility previously and was re-admitted after not doing well living at home with her spouse. RN-B stated the dietary manager (CDM) was responsible for assessing each resident, "So we can maintain their weight and their health." R46's Weights and Vitals Summary report dated 10/21/16, identified the following weights recorded for R46:	F 325	committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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F 325	Continued From page 49 10/18/16 - 102 (pounds) 10/6/16 - 105.2 9/23/16 - 104.5 7/23/16 - 104 5/31/16 - 109.2 R46's progress note dated 8/19/16, identified a, "WEIGHT WARNING," as R46 had sustained a, "-10.0% change" in her weight since 8/4/16. Further, the note identified staff would, "Continue to monitor weight and oral intakes for changes." There was no comprehensive assessment of R46's nutritional status identified in the progress notes, despite this warning being triggered. During interview on 10/20/16, at 2:57 p.m. CDM-A stated a comprehensive nutritional assessment would include a review of the residents weight, pertinent medical history, medication consumption, laboratory data, likes and dislikes, and their intake patterns. CDM-A stated she was responsible to complete nutritional assessments for each resident, however had not completed one for R46 when she re-admitted to the facility, "I don't see it." CDM-A stated a resident who was not assessed, "May not be getting what they need nutritionally," and added R46 had never been assessed or screened by the facility registered dietician. Further, CDM-A stated R46's weight on her discharge to home on 5/31/16, was 109 pounds and her weight upon re-admission to the facility was 104 pounds on 7/23/16, which would be considered, "Significant," weight loss. A facility Nutritional Guidelines dated 10/2014, identified a standard to provide, "Appropriate treatments of reversible conditions are addressed to alleviate any disruptions to adequate nutritional intake." Further, the policy directed, "The	F 325		

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F 325	Continued From page 50 nutrition assessment is completed on admission, annually and with any significant change in status or weight loss of 5% in 30 days or 10% in 160 days."	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with manufacturer recommendations and physician orders for 1 of 8 residents (R62) observed during a medication pass which resulted in a facility medication administration error rate of 6.45% (percent). Findings include: R62's signed Medication Review Report dated 10/14/16, identified physician orders for R62 to receive the following medications while at the facility: - "Omeprazole [medication used to reduce stomach acid] Capsule Delayed Release 20 MG [milligrams] ... by mouth one time a day related to PERSONAL HISTORY OF OTHER DISEASES OF THE DIGESTIVE SYSTEM," and; - "Zenpep Capsule Delayed Release particles [medication used to help digest food] 20000 UNIT ... Give 1 capsule by mouth three times a day	F 332	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R62 has been discharged from the facility. Medication Error Form was completed for LPN-C regarding the timing of Omeprazole administration. Medication error Form was completed for nurses involved with Zenpep error. 2. All residents receiving Proton Pump Inhibitors have had the timing of administration changed to 7:00 am to ensure it is received on an empty stomach. MAR's were reviewed to ensure no other medications had been placed on	11/25/16

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F 332	Continued From page 51 related to PERSONAL HISTORY OF OTHER DISEASES OF THE DIGESTIVE SYSTEM." During observation of medication administration on 10/20/16, at 9:24 a.m. licensed practical nurse (LPN)-C prepared R62's medications at a mobile cart in the hallway outside her room. LPN-C removed a medication punch card and provided it to the surveyor for review. The card was labeled, "OMEPRAZOLE 20 MG CAP [capsule]," and had a sticker fixed to it which identified, "Take This Medicine Before A Meal Or As Directed By Your Doctor." LPN-C stated she had previously observed R62 at breakfast eating, "A good half hour ago." LPN-C removed a single capsule and placed it in a cup for administration before continuing to page through the Medication Administration Record (MAR) and prepare additional medications. LPN-C stated R62 was scheduled to receive a Zenpep capsule during this same medication pass, however the medication was not available. LPN-C finished preparing R62's medications, including the Omeprazole, and administered them to R62 in her room. R62's MAR dated 10/2016, identified an order for, "Omeprazole Capsule Delayed Release 20 mg ... Give 20 mg by mouth one time a day..., with an identified administration time of, "0730 [7:30 a.m.]." Further, the MAR identified an order for, "Zenpep Capsule Delayed Release ... Give 1 capsule by mouth three times a day related to...," with a start date of 10/14/16. The MAR providing spacing for staff to initial when the medication was provided, however the medication had not been provided since ordered on 10/14/16. Instead, the MAR identified circled initials (not administered) and had, "No Med," written in the	F 332	hold without appropriate follow up. 3. Medication administration practice guidelines were reviewed including documentation and follow up required when placing a medication on hold. All Licensed staff were re-educated on the appropriate timing for the administration of Proton Pump Inhibitors. 4. DNS or designee will conduct weekly audits x1 month and then monthly audits x2 months to ensure Proton Pump Inhibitors are scheduled and administered at the appropriate times. Medication Administration records will also be audited on this schedule to ensure medications placed on hold have appropriate documentation and follow up. Audit results and the data collected will be presented to the QAPI Committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016	

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F 332	Continued From page 52 spacing from 10/14/16 until 10/20/16. When interviewed on 10/20/16, at 9:37 a.m. LPN-C stated R62's Omeprazole was scheduled to be given at 8:00 a.m. but should be rescheduled to be given before she eats, "This one [Omeprazole] should be given at six [a.m.]." LPN-C stated Omeprazole should be given before meals, "To protect" her stomach. Further, LPN-C stated she was unaware why R62 was not receiving the ordered Zenpep as identified in her MAR and adding she was unaware if anyone had addressed it with the pharmacy or physician. During interview on 10/20/16, at 10:05 a.m. LPN-B stated R62's Zenpep medication required a previous authorization before pharmacy would fill the prescription. The staff faxed R62's primary physician for the authorization, however R62's physician referred the staff to the gastrointestinal (GI) physician instead. LPN-B stated the authorization had not been attained and had been missed by staff until the surveyor brought it to their attention, "I just did it right now." Further, LPN-B stated since the medication was not here because of the lack of follow through to obtain the preauthorization, it would be considered a medication error for R62. When interviewed on 10/20/16, at 10:11 a.m. registered nurse (RN)-A stated R62 should have been given her ordered Omeprazole, "before they eat in the morning," as it, "Needs to be given on an empty stomach." RN-A stated the administration of Omeprazole after breakfast and not following up on R62's Zenpep would be a medication error. During interview on 10/20/16, at 10:42 a.m. the	F 332		

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F 332	Continued From page 53 consulting pharmacist (CP) stated Omeprazole should be administered on a, "Preferably empty stomach," as it was, "More effective," and not doing so would be considered a medication error. Further, CP stated R62's Zenpep medication would, "Aides in digestion," and staff should have followed through in ensuring it had been received. Further, CP stated the lack of administration of R62's Zenpep would be considered a medication error, "To me, its a med error." When interviewed on 10/20/16, at 11:54 a.m. the director of nursing (DON) stated R62's Omeprazole should have been given, "On a empty stomach," and staff should have followed up with R62's gastroenterologist to ensure her Zenpep was available for administration. Further, the DON stated these examples would be considered medication errors. An undated manufacturer Medication Guide for Omeprazole identified directions under the spacing labeled, "How should I take PRILOSEC [Omeprazole]," which included, "Take PRILOSEC before a meal." A facility Medication Administration - Licensed Nurse policy dated 8/14, directed staff to, "Compare the information on the MAR with the label on the medication container" to help verify medication is given at the, "Time that the medication should be given."	F 332		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		11/25/16

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F 465	Continued From page 54 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms, wheelchairs, and kitchen equipment was kept clean and in good repair for 10 of 22 occupied room (W10, W18, W5, W16, W17, E1, E17, E4, E6, E9) that affected 8 residents who live in these rooms; 1 of 5 resident (R47) wheelchairs, and 27 of 29 residents who were served food from the kitchen. Findings include: RESIDENT ROOMS The facility environment was observed on 10/19/16 during the afternoon, the following environmental issues were noted: Room W-10 There was chipping paint on the wall behind the resident's door in his room. The area was approximately 4 inches by 12 inches where paint was peeling from the wall, with paint chips noted on the floor. There were several holes in the wall in the bathroom where a soap dispenser once hung. A ceiling fan in the bathroom had visible dust on the fan blades. Room W-18 had a 3 inch x 3 inch hole in the dry wall to the left of bed B. Room E-1 bed B, which was next to the window had parts of the window sill jam was missing. The full length of the window sill jam that extended into the resident room had broken off. This	F 465	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Room W-10: Wall behind the resident's door was painted and paint chips were removed from floor. Holes in wall were patched and wall was repainted. Ceiling fan was dusted. Room W-18: hole in wall was patched and painted. Room E-1: Window silk was fixed. End cap to base board heating unit was replaced. Room W-5: Chipped tiles were replaced and the bathroom was cleaned. Room W-17: Bathroom floor was cleaned and black marks removed. Outlet phone plug was secured to the wall. Tile and grout fixed. Room E-17: Hole patched and sheetrock replaced. Room E-4: Scrapes on wall were patched and painted. Saw dust removed. Room W-16: Outlet on wall was fixed and secured into place. Bathroom vent was cleaned. Sheetrock behind bed was patched and painted. Bathroom door frame was dusted. Wooden door in	

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F 465	Continued From page 55 exposed rough, splintered wood, and crumbling particle board that was part of the window jam. The base board heating unit, which ran the width of the window side of the room, had an missing end cap. Room W-5 walls in the bathroom had chipped tiles, dirty walls with build up on walls, floor is dirty and sticky when standing in bathroom. Room W-17 white bathroom floor had black marks, and an outlet phone plug was not secured to the wall. There was missing tile inside the bathroom that was approximately 8 inches, and the area also had grout missing from between the tiles. Room E-17 had a large 3 inch hole in the sheetrock on the wall near the resident bathroom, there were two smaller scrapes also in the bathroom. Room E-4 there was sheetrock dust laying on the floor with 8 large scrapes on the resident's wall. Room W-16 Had an outlet hanging from wall with wires in it nothing plugged in it. A vent on bathroom ceiling was dirty with dust hanging down. At the head of the bed were several gouges in the drywall from the headboard of the bed rubbing while the bed was raised and lowered. The bathroom door frame was covered in white chalky material on the brown metal frame. The bathroom wooden door had gouges that were approximately 12 inches long and 1/8 inch wide. Room E-6 Bathroom vent had a heavy build up of dark, dusty debris.	F 465	bathroom was fixed. Room E-6: Bathroom vent was cleaned. Room E-9: Scrapes on wall were patched and painted. R47 had Left side arm rest on wheelchair secured. Exhaust hoods above the oven, stove, and steamer in kitchen were cleaned. 2. Administrator and Maintenance Director completed a room to room facility walk through and identified areas requiring attention. 3. A monthly facility walk through will be completed by the Administrator and Maintenance Director to identify areas of concern. 4. Administrator or designee will complete random monthly audits x2 months to ensure identified areas of concern have been addressed. Audit results and the data collected will be presented to the QAPI Committee monthly by the Administrator or designee. QAPI committee will review and make any necessary recommendations. 5. Corrective action will be completed by November 25th, 2016.	

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F 465	Continued From page 56 Room E-9 had scrapes on the wall behind the resident's bed that were approximately 4 inches by 4 inches, with paint missing. During interview on 10/20/2016 12:16 p.m., the maintenance director (MD) stated that a local cabinet company was sent pictures of the broken window sill requesting a quote approximately 2 weeks ago, and had not heard anything from the company. The MD was unable to provide documentation this had been completed. The above rooms were discussed with MD, who was unaware of the repairs that needed to be completed. The MD stated there was a facility three ring binder at the nursing station that staff are to write any room repairs or concerns. Then maintenance would complete the repairs, which had not been completed. A policy was requested for facility repair identification / reporting / repair, and was informed on 10/21/2016 at 10:00 a.m., by the administrator and MS that there was none. WHEEL CHAIR During observations on 10/18/2016 at 12:27 p.m., R47's left wheelchair (WC) arm rest had one of the two screws missing that held the rest in place. The missing screw allowed the arm rest to move freely, making it difficult to keep the residents arm at rest. R47 stated that it had been that way for "a week or so". She thought the nursing assistants knew about it, but was not sure. KITCHEN	F 465		

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F 465	Continued From page 57 During the initial tour of the kitchen, on 10/17/16 at 8:06 a.m., there were two sections of exhaust hoods above the oven, stove and steamer area. The hood on the left section had a visible moderate amount of greasy/fuzzy build-up. During interview on 10/17/16 at 11:20 a.m. the certified dietary manager (CDM) stated the screens are schedule to be cleaned every 3 months, but are clean as needed. A blank copy of the Cooks Cleaning Schedule (undated) was provided. The sheet identified the exhaust hoods (one by the steamer and one buy the range) were scheduled to be cleaned "monthly".	F 465		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245375	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

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 or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245375	A. BUILDING: _____ B. WING _____	10/21/2016

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 2 of 3 residents (R59, R8) reviewed for liability notices were provided the required Notices of Medicare Non-coverage upon termination of their covered services.

Findings include:

R59's progress note dated 10/4/16, identified R59 had reached her therapy goals and, "Planned discharge from therapy on Thursday [10/6/16]." Further, the note identified R59 was planned to discharge the facility to her home on 10/7/16.

R59's medical record was reviewed and lacked evidence R59 had been provided a Notice of Medicare Non-coverage (CMS-10123) as required.

R8's progress note dated 9/26/16, identified R8 would complete, "Antibiotic on Thursday the 29th [9/29/16]," and would, "Discharge back to group home on Friday 9-30-16."

R8's medical record was reviewed and lacked evidence R8 had been provided a Notice of Medicare Non-coverage as required.

When interviewed on 10/21/16, at 9:47 a.m. registered nurse (RN)-B stated R59 and R8 both admitted to the facility for covered services under the Medicare A benefit. RN-B stated R59 and R8 reached their identified goals with no further skilled services being available and had, "Planned discharge plans in place." Further, RN-B stated R59 and R8 did not have any notices of liability provided as, "They had a planned discharge home and there was going to be no change in their payer source."

During interview on 10/21/16, at 9:53 a.m. the director of nursing (DON) stated R59 and R8 should have been provided a Notice of Medicare Non-coverage, "48 hours before their last covered day [of services]."

A facility Medicare Beneficiary Notice Requirements for Skilled Nursing Facilities policy dated 6/2012, identified residents whose Medicare Part A services were ending should receive a CMS-10123 because the, "Provider [facility] determines that beneficiary no longer requires daily, skilled services."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURAGE KENNY REHABILITATION INSTITUTE'S TRP	**3915 GOLDEN VALLEY ROAD** **GOLDEN VALLEY, MN 55422**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 06, 2016. At the time of this survey, Courage Kenny Rehabilitation Institute was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II(111) construction. It has no basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 41 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

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 _____	**10/21/2016**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 21, 2016. At the time of this survey Sterling Park Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. Building 01 of Sterling Park Healthcare Center was constructed as follows: The original building was built in 1963, is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction; The 1983 building addition is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction The 2003 building addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 53 beds and had a census of 30 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **02 - 2010 ADDTION** B. WING _____	**10/21/2016**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 21, 2016. At the time of this survey Sterling Park Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. Building 02 of Sterling Park Healthcare Center consists of the 2010 Courtyard Great Room addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 53 beds and had a census of 30 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.