DEPARTMENT OF HEA	MED	ICARE/MEDICA			ND TRANSMITTAL	MEDICARE & MEDICAID SERVICES ID: 6U13			
1. MEDICARE/MEDICAID PRO (L1) 245375 2.STATE VENDOR OR MEDICA (L2) 502490100	VIDER NO.	3. NAME AND ADI (L3) STERLI	DRESS OF FACILI NG PARK R 142 NOR	TY HEALT FH FIRS	E SURVEY AGENCY H CARE ST STREET (L6) 56387	Facility ID: 00643 4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
 5. EFFECTIVE DATE CHANGE (L9) 6. DATE OF SURVEY 	COF OWNERSHIP 3/4/2014 (L34)	7. PROVIDER/SUP01 Hospital02 SNF/NF/Dual	PLIER CATEGOR 05 HHA 06 PRTF	8Y 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
	(L10) 1 TJC 3 Other	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
 11LTC PERIOD OF CERTIFICA From (a): To (b): 12.Total Facility Beds 	TION 53 (L18)	10.THE FACILITY I X A. In Complian Program Rei Compliance 1. A	ce With quirements	:	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size X5. Life Safety Code 9. Beds/Room				
13. Total Certified Beds	53 ^(L17)	* Code: A,5	(L12)						
14. LTC CERTIFIED BED BREAD	KDOWN			15. FACILITY MEETS					
18 SNF 18/	19 SNF 19 SNF 53	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38) (L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY F	REMARKS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:				
Tim Rhonem	nus, HFE NE II		3/11/2014	(L19)	Kate JohnsTon, Enfo	orcement Specialist 3/24/2014			
	PART II - TO	BE COMPLETEI) BY HCFA R	EGIONAL	OFFICE OR SINGLE STAT	EAGENCY			
 DETERMINATION OF ELIC 1. Facility is Eligi 2. Facility is not I 	ble to Participate	20. COM RIGH	CIVIL		ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)				
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)			
OF PARTICIPATION BEGINNING DATE ENDING DATE 12/01/1986			Έ	VOLUNTARY 00 01-Merger, Closure 0	INVOLUNTARY 05-Fail to Meet Health/Safety				
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement			
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:					03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 00-Active				
(I		pension Date:	(L44)			00110010			

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

02/15/2014

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00643

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

NH-PCR Page 2 Provider Number: Item 16 Continuation for CMS-1539

On December 19 and 20, 2013, the Departments of Public Safety and Health completed an extended survey which found the most serious deficiencies to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

Pursuant to those findings we imposed:

--State Monitoring effective January 15, 2014. (42 CFR 488.422)

On February 21, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

--Per instance civil money penalty of \$6000.00 for the deficiency cited at F0323, effective December 19, 2013, for a total penalty of \$6,000.00. (42 CFR 488.430 through

488.444)

--Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2014. (42 CFR 488.417 (b))

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. The facility's request for a continuing waiver involving the deficiency cited at K55 is recommended for approval. Documentation supporting the waiver request is attached. Effective January 4, 2014, the facility is certified for 53 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245375

March 11, 2014

Ms. Heather Potter, Administrator Sterling Park Health Care Center 142 North First Street Waite Park, MN 56387

Dear Ms. Potter:

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 January 24, 2014, the above facility is certified 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,

Inston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 11, 2014

Ms. Heather Potter, Administrator Sterling Park Health Care Center 142 North First Street Waite Park, Minnesota 56387

RE: Project Number S5375024

Dear Ms. Potter:

On January 10, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective January 15, 2014. (42 CFR 488.422)

On February 21, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Per instance civil money penalty of \$6000.00 for the deficiency cited at F0323, effective December 19, 2013, for a total penalty of \$6,000.00. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on December 20, 2013. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On March 4, 2014, the Minnesota Department of Health and on February 19, 2014, the Department of Public Safety completed Post Certification Revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on December 20, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 24, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on December 20, 2013, as of January 24, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 24, 2014.

However, as we notified you in our letter of January 10, 2014, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 19, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 21, 2014:

• Per instance civil money penalty of for the deficiency cited at F0323, effective December 19, 2013, for a total penalty of \$6,000.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2014 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Your request for a continuing waiver involving the deficiency(ies) cited under K055 at the time of the December 20, 2013 extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Grenda Liscler

Brenda Fischer, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (320)223-7338 Fax: (320)223-7348 Enclosure cc: Licensing and Certification File

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245375	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/4/2014
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).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
	ix F0157		Completed 01/24/2014		ID Prefix	E0164		Completed 01/24/2014		ID Prefix	E0166		Completed 01/24/2014
								01/24/2014					
Keg. LS	# 483.10(b)(11) C		-		Reg. # LSC	483.10(e), 483.75(l)(4)			Reg. # LSC	483.10(f)(2)		
			-										
			Correction					Correction					Correction
			Completed					Completed					Completed
	ix F0225		01/24/2014		ID Prefix			01/24/2014		ID Prefix			01/24/2014
Reg. LS	# 483.13(c)(1)(ii)-(iii), (c)(2) -	(4)		Reg. # LSC	483.13(c)				0	483.15(c)(6)		
			-		130					130			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pret	ix F0248		01/24/2014		ID Prefix	F0282		01/24/2014		ID Prefix	F0309		01/24/2014
	# 483.15(f)(1)		-		•	483.20(k)(3)(ii)					483.25		
LS	۵		-		LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pret	ix F0314		01/24/2014		ID Prefix	F0323		01/24/2014		ID Prefix	F0353		01/24/2014
-	# 483.25(c)		_			483.25(h)				-	483.30(a)		
LS	C		-	<u> </u>	LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pret	ix F0356		01/24/2014		ID Prefix	F0441		01/24/2014		ID Prefix			
Reg.	# 483.30(e)		_		0	483.65				Reg. #			
LS	C		-		LSC					LSC			
Reviewed	Ву	Reviewed	Ву	Da	te:	Signature of S	Surve	yor:				Date:	
State Age	ю		BF/KJ	3	8/11/20	14		2079	94			3	/4/2014
Reviewed	Ву	Reviewed	Ву	Da	te:	Signature of S	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of											
12/20/2013				Uncor	recte	d Deficiencies	s (CM	S-2567) Sent	to the Facility?	YES	NO		

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00643	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/4/2014
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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix	20265		01/24/2014		ID Prefix	20565	01/24/2014		ID Prefix	20800		01/24/2014
0	MN Rule 4658.008	35			•	MN Rule 4658.0405 Subp.	3		0	MN Rule 4658.0	0510 Subp	b. 1
LSC					LSC		-		LSC			_
			Correction				Correction					Correction
			Completed				Correction Completed					Correction Completed
ID Prefix	20830		01/24/2014		ID Prefix	20905	01/24/2014		ID Prefix	21375		01/24/2014
Reg. #	MN Rule 4658.052	20 Subp.	1		Reg. #	MN Rule 4658.0525 Subp.	4		Reg. #	MN Rule 4658.0	0800 Subr	b. 1
LSC					•		_		LSC			
				1								
			Correction				Correction					Correction
ID Profix	21426		Completed 01/24/2014		ID Prefix	21425	Completed 01/24/2014		ID Prefix	24955		Completed 01/24/2014
			-				_					
	MN St. Statute 14				0	MN Rule 4658.0900 Subp.	1			MN St. Statute		Subd. 1
					200		_		200			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix	21880		01/24/2014		ID Prefix	21990	01/24/2014		ID Prefix	22000		01/24/2014
Reg. #	MN St. Statute 14	4.651 Sul	od. 2		Reg. #	MN St. Statute 626.557 Su	ıbd. 4		Reg. #	MN St. Statute	626.557 \$	Subd.
LSC					LSC		-		LSC			_
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Reg. #			-		Reg. #		_		Reg. #			
LSC					LSC				LSC			
Reviewed By	v Re	eviewed E	Βv	Da	ite:	Signature of Surve	evor:	1			Date:	
State Agenc			BF/KJ		3/11/20	_	-	794				/2014
Reviewed By	-	eviewed E	· · ·	Da	<u>5/11/20</u> ite:	Signature of Surve					Date:	
CMS RO			-				-					
Followup to	Survey Completed	d on:		+		Check for any	Uncorrected	Defic	iencies Was	a Summary of		
12/20/2013					Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			NO				
STATE FORM	M: REVISIT REPOR	RT (5	/99)			Page 1 of 1				Event ID:	6U1312	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245375	(Y2) Multiple Construction A. Building B. Wing	0 ADDTION	(Y3) Date of Revisit 2/19/2014
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).

(Y4) It	em		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
ם סו	rofiv			Completed 01/24/2014		ID Drofiv			Completed 01/24/2014		ID Drofiv			Completed 01/24/2014
	refix			01/24/2014					01/24/2014					01/24/2014
	•	NFPA 101 K0050				0	NFPA 101 K0052				•	NFPA 101 K0062		
	200	10030				200	10032			+		10002		
				Correction					Correction					Correction
				Completed					Completed					Completed
ID P	refix			01/24/2014		ID Prefix			-		ID Prefix			
	-	NFPA 101				Reg. #					Reg. #			
	LSC	K0144				LSC					LSC			
				0 "					0 "					0 "
				Correction					Correction					Correction
ID P	refix			Completed		ID Prefix			Completed		ID Prefix			Completed
Re	eg. #			-		Reg. #			-		Reg. #			
	LSC													
										+-				
				Correction					Correction					Correction
ם סו	rofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
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	eg. # LSC					Reg. #					Reg. #			
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				Correction					Correction					Correction
				Completed					Completed					Completed
ID P	refix			-		ID Prefix					ID Prefix			
	eg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			
Reviewe	ed By		Reviewed E	Зу	Da	te:	Signature of	Surve	vor:				Date:	
State Ag	gency	,		PS/KJ		3/11/20	-		2720	00				/19/2014
Reviewe	ed By		Reviewed B	Зу	Da	te:	Signature of	Surve	yor:				Date:	
CMS RC	D													
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of											
12/19/2013					Unco	orrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO		



Protecting, Maintaining and Improving the Health of Minnesotans

March 11, 2014

Ms. Heather Potter, Administrator Sterling Park Health Care Center 142 North First Street Waite Park, Minnesota 56387

Re: Enclosed Reinspection Results - Project Number S5375024

Dear Ms. Potter:

On December 20, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 4, 2014, with orders received by you on January 15, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Grenda Lischer

Brenda Fischer, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (320)223-7338 Fax: (320)223-7348 Enclosure(s)

cc: Original - Facility Licensing and Certification File

DEPARIMENT OF HEALTH A							DICARE & MEDI	ICAID SERVICES			
		ARE/MEDICAII TO BE COMPL						ID: 6U13 Facility ID: 00643			
1. MEDICARE/MEDICAID PROVIDER N (L1) 245375		3. NAME AND AD (L3) STERLING	DRESS OF FAC	ILITY			4. TYPE OF ACT	-			
2.STATE VENDOR OR MEDICAID NO. (L2) 502490100		(L4) 142 NORTH (L5) WAITE PAR		ЕТ	(L6)	56387	3. Termination 5. Validation	4. CHOW 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other îter Complaint			
6. DATE OF SURVEY 12/20/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	13 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/II 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAR ENDING DATE: 09/30				
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED A	AS:							
From (a): To (b): 12.Total Facility Beds	60 (L18)	 A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC 			And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room						
13.Total Certified Beds 60 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B,5							(L12)				
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY M	EETS					
18 SNF 18/19 SNF 60	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)				
(L37) (L38)	(L39)	(L42)	(L43)								
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION E	DATE):							
See Attached Remarks											
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL	Date:			
Jessica Sellner, HFE NE II		0	1/30/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 02/10/2014 (L20)						
PART	II - TO BE (COMPLETED B	BY HCFA RE	GIONA	L OFFICE OR	SINGLE S	TATE AGENCY				
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partic 2. Facility is not Eligible 			PLIANCE WITH ITS ACT:	I CIVIL	2. O		ncial Solvency (HCFA-2 ol Interest Disclosure Str :	<i>,</i>			
22. ORIGINAL DATE 22	3. LTC AGREEN	MENT 24	. LTC AGREEM	IENT	26. TERMINAT	TION ACTION:		(L30)			
OF PARTICIPATION 12/01/1986	BEGINNINC		ENDING DAT		<u>VOLUNTARY</u> 01-Merger, Closu	00	INVOL	UNTARY to Meet Health/Safety			
(L24)	(L41)		(L25)		02-Dissatisfaction			to Meet Agreement			
25. LTC EXTENSION DATE: 27		VE SANCTIONS n of Admissions:			03-Risk of Involut 04-Other Reason	•	OTHER	tider Status Change			
(L27)				00-Activ	-						
			(L45)								
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS						
		03001									
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE							
	(L32)			(L33)	DETERMINA	ATION APPI	ROVAL				

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 6U13 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00643

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CNN-24-5375

On December 20, 2013, a NOTC extended survey was completed at this facility. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The most serious deficiencies were issued at a S/S level of J (F323). The IJ was identified on December 19, 2013 at 6pm and was abated on December 20, 2013 at 2pm.

As a result of the survey findings. We have imposed State monitoring, effective December 15, 2013. In addition, we have recommended to the CMS RO the following remedy for imposition and CMS has concurred.

A civil money penalty for deficiency cited at F323.

Due to the extended survey and finding of substandard quality of care, the facility is subject to a loss of NATCEP for two years from December 20, 2013.

Documentation supporting the facility's request for a continuing waiver involving LSC K55 is being recommended and forwarded to CMS for approval.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3889

January 10, 2014

Ms. Heather Potter, Administrator Sterling Park Health Care Center 142 North First Street Waite Park, Minnesota 56387

RE: Project Number S5375024

Dear Ms. Potter:

On December 20, 2013, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

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

<u>Informal Dispute Resolution</u> - 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on December 20, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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 Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7338 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective January 15, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

Civil money penalty for the deficiency cited at F323, effective December 19, 2013. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the</u> <u>following information, you are required to provide to this agency within ten working days of</u> <u>your receipt of this letter the name and address of the attending physician of each resident found</u> <u>to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Sterling Park Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 19, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 19, 2014 (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 June 19, 2014 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

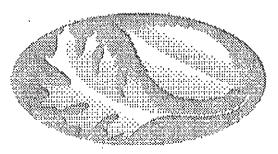
Enclosure

cc: Licensing and Certification File

5375s14.rtf

(FAX)3202525940





Sterling Park Health Care Center

142 1st Street North

Waite Park, MN 56387

(320) 252-9595

Addendum to Plan of Correction for survey dated 01/11/2013

F279 Add, All resident's in facility will be reviewed for fall risk upon admission, quarterly and with significant change in condition and care planned accordingly.

Add, all residents with dialysis orders will be care planned to include access site, special care and procedures.

- F309 Add, all resident's with orders for dialysis will have proper dialysis procedures in place according to facility policy and procedure.
- F323 Add, all resident's will be assessed for fall risk upon admission, quarterly and with significant change in condition and care planned accordingly.
- F329 Add, All resident's will have proper documentation on the efficiency of as needed medications per facility policy and procedure.

3/23/14

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	by: Based on observa review, the facility f residents, (R16) wh medications, was a	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 no self administered ssessed for safe self n inhalation medication.						
	was admitted to the services. The minir	of a fractured left femur and facility for rehabilitation num data set (MDS) dated R16 was cognitively intact but	A of	Norder J	yn.		:	
	During observation	and resident interview on	NX	, the				
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F.1.76	reported as missing was observed on the nightstand. R16 ind went missing, her he from home. R16's physician ord "Albuterol 90 MCG inhalation-PRN as the bedside." R16's medical reconself administration however there was provision for self administration reconself administration reconself administration reconself administration record January 1-11, 2013 When interviewed of assistant director of did assess R16 for not for the inhaler the further stated that F to record if she use self administration When interviewed of stated she usually of day or less, "some breathing is OK". F given a sheet to reconstruction in the interviewed of the stated she usually of and a sheet to reconstruction of the sheet to reconstruction of the sheet to reconstruction. When interviewed of the sheet to reconstruction of	R16 stated her inhaler was personal property. An inhale icated that after the inhaler usband brought another on lers dated 10/26/12 included (microgram)/actuation sol needed. May have inhaler a rd revealed an assessment of Nebulizer treatment, no assessment or care plan lministration of the inhaler of the medication rd (MAR) indicated R16 r 1 time on December 4, 20 of receiving the inhaler from	ler e d at for n 12 n 12 n 2y e AR	176	 F 176 The preparation of the following correction for this deficiency doe constitute and should not be interest as an admission nor an agreem the facility of the truth of the face alleged or conclusions set forth statement of deficiencies. The correction prepared for this defivered was executed solely because p of state and federal law require. Without waiving the foregoing statement, the facility states wit to: Residents # 16 has had a set administration of medication assessment completed. Care p been updated. Resident #16 has been provided a MAR to record often she is taking the medicati provided education on how to reappropriately. All residents requesting to set administration of medications will hav current assessment completed planned accordingly. Nursing staff education will be completed by February 18, 201 trained on policy and procedure administration of medications. The DNS and/or her designed conduct one audit weekly on an residents requesting to self administrations, and current resider doing Self Administration for pristorage and documentation. 	es not erpreted ent by ts in the plan of ciency rovisions it. h respect elf lan has as also how on and ecord lf e a and care e 3, e of self e will ny ninister ents	6 (143) 7 (144) 7 (144) 7 (144) 7 (144) 7 (144) 7 (145) 7 (
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F279	ulcer, nor was the h avoiding pressure is with other interventi- healing R63's press A review of the facil Guidelines, dated 1 Policy, "The individu prevention strategie effectiveness of inter revisions/modificatii information, a chan or a new intervention On 1/9/13 at 2:21 p verified R63's care include an actual pr Even though R63 h on the CAA dated 8 care planning would failed to review and plan of care. R9 was admitted to had 11 documented care plan was not u interventions to help R9 has diagnoses t incontinence, depre admission Minimum 10/27/2012 included	R63 had a current pressure lospital discharge orders of dentified in the care plan along lons or treatments to assist in bure ulcer. lity's Pressure Ulcer 0/21/10, included under ualized care plan addresses es, reassessments of the erventions and ons based on new ge in the resident's condition on." .m., registered nurse (RN)-C plan had not been updated to ressure ulcer. ad pressure ulcers identified be completed, the facility revise R63's comprehensive the facility on 10/2012 and d falls since admission. The pdated to include to reduce the risk of falls. hat include: urinary ession and anxiety. R9's in Data Set (MDS) dated d she had moderate cognitive puired extensive assistance of	F	279	F 279 continued The preparation of the fol of correction for this defic not constitute and should interpreted as an admissi agreement by the facility of the facts alleged or cor set forth in the statement deficiencies. The plan of prepared for this deficience executed solely because of state and federal law re Without waiving the foreg statement, the facility stat respect to: 1. Resident # 9 a ne analysis was com 1/25/2013. A new and bladder asse was also complet 1/24/2013. Care updated accordin findings of new assessments and fall interventions. with IDT	iency does not be on nor an of the truth aclusions of correction cy was provisions equire it. oing es with w fall risk apleted on y bowel ssment ed on plan gly with	311 4 64 43 4 64 44 4 64 44
FORM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: O42V1	1	Fac		continuation she	et Page 5 of 43
							2742-031 (449) (44

		AND HUMAN SERVICES				OMB NO	APPROV . 0938-03
ATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONS	TRUCTION	(X3) DATE S	URVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			COMPL	ETED
			B. WING				
		245375	D. WING	·	· · · · · · · · · · · · · · · · · · ·	01/1	1/2013
AME OF F	ROVIDER OR SUPPLIER		s	TREET ADDR	ESS, CITY, STATE, ZIP CODE		
TERLIN	IG PARK HEALTH CA				I FIRST STREET ARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
Â.				2	. Staff care sheets have	been	19
F 279	Continued From pa	ge 5	F 27	'9	updated to reflect curre	ent	Lin
	Review of "undated	nursing assistant care sheet",			fall interventions and		1997) 1997)
• .*		bilet resident every 1.5 hours		-	toileting schedule.		5.11 -
• # 4 · •		or in bed. There was no		3	. Education regarding ca		13. 1945 - 1945 - 1945 1947 - 1945 - 1945
• •	mention of the TAB	S alarm.			sheet updating and pro		(X
	Review of "uptified	document" for January 2013,			alarm placement will b provide by February 18		
•		pad sensor when in bed. No			2013.	,	
		bs to resident Start Date:		4			1.7/2
- EF E Notes		day/evening/night) Everyday."			designee will complete	two	
MIC					audits per week for on		1.0-0
anger Here		1/9/2013 at 12:55 p.m.,			month then weekly for		
•		IA)-D stated the TAB alarm			months.		
; •		to R9 at all times, and they		5		be	يلين المراجع ا مراجع المراجع ال
 ^	attached the alarm	to the back of R9's sweater.			presented to the QA		30
	Review of R0's car	e plan, last updated 11/26/12,			Committee by the DNS The data collected will		
		be toilet resident every 1.5			reviewed/discussed at		1 1 2 4
		Is, pressure pad sensor while			quarterly QA meeting.		
. •		te resident to lunch and			this time the QA Com		1 223 中国代生刊
	supper and to toilet	to prevent falls. There was no		ł	will make the		VATE
an.		ad a personal protective alarm			decision/recommendat		1997
1. 1.	(TABS) to alert staf	f when she moved.			regarding any follow-u	р	5 50
	During intonviow on	1/10/13 at 3:15 p.m. the			studies.		1 23 Juli 1 24 Juli
and the second secon		stated R9's TABS alarm may					1.2.40
		for her at this time and verified		Comple	etion date: February 19, 2	013	
		ed on the care plan.					12.50
	The facility failed to	complete a comprehensive					
÷.,		access site, special care, and					. 49
141		ares for R45 and R75 who					
	received hemo-dial	ysis.					
	R45 was discover	with end stage renal disease.					
2.493 1. 52		m Data Set (MDS) dated					4 1 1
•		R45 as cognitively intact,					میں اور
•• •		l activities of daily living		-			
	(ADLs), and receive						

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		I AND HUMAN SERVICES				FORM	01/29/2013 APPRŐVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	ETED
		245375	B. WI	NG .	an a su a a su a su a su a su a su a su	01/1	
	ROVIDER OR SUPPLIER			ŧ.	REET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET		ा - 0VEL
STERLIN	IG PARK HEALTH CA			ł	WAITE PARK, MN 56387	· • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 6	F	279		-,	6 of 4
	During review of R4 11/01/12, indicated	15's care plan, last revised on			F 279 continued		757 14 (7-710) 19 (7-710)
	"hemo-dialysis thre stage four chronic l	e times a week related to kidney disease, scheduled ondays, Wednesdays and			The preparation of the follow of correction for this deficien not constitute and should no	cy does t be	
	Fridays with transp observe/ document	ort by Care Cab and staff to to medical practitioner/ nurse			interpreted as an admission agreement by the facility of t of the facts alleged or conclu	he truth	
THE. TEM., MA	of the following, ble	or s/sx [signs and symptoms] eding, hemorrhage and septic no information regarding; the			set forth in the statement of deficiencies. The plan of co	rrection	35.0391
	access site locatior or whom the facility	h, checking bruit and thrill daily should contact, if R45 was			prepared for this deficiency v executed solely because pro of state and federal law requ	visions	يە تىر ، بە تىر ، ، ، بەر ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ،
i C	concerns.	lysis due to weather related			Without waiving the foregoin statement, the facility states	g	1142012 107420 118361
	director of nursing vinformation on R45	on 01/11/13, at 9:50 a.m. the verified there was no dialysis 's and R75's care plan			respect to: 1. Resident # 45 care was updated on 2/4, to include access sit	/2013,	145) 741 (25)
		cy procedures, where the ated and any special cares			special care and procedures. 2. Resident # 75 care		
· · · ·		l with end stage renal disease.			was updated on 2/6 to include access sil special care and	/2013,	Ship B of 4
		S dated 12/27/12 identified ntact, extensive assist with I hemo-dialysis.			procedures. 3. Education regarding	j	
144,		75's care plan, last revised on resident "needs hemo-dialysis			emergency dialysis procedures will be p by February 18, 201		
ф. <u>(М.).</u>	related to end stage	e renal disease, check and access site. Document.			4. The DNS and/or her designee will compl	ete two	30VED 30-0391
1000 - 1000 - 1000 - 1000 - 1000 - 1000	Friday- p/u [pick up	londay, Wednesday and] at 0530, and staff to observe/ al prostitioner / purso PRN (as			audits per week for month then weekly months.		
	needed] for s/sx [si	al practitioner / nurse PRN [as gns and symptoms] of the hemorrhage and septic					1990) 1990) 1997(9
FORM CMS-26		Obsolete Event ID: 042V11		F	acility ID: 00643 If cont	inuation shee	t Page 7.of 43
							• : : : : : : : : : : : : : : : : : : :

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 01 FORM API OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		245375	B. WING		01/11/2	0132953
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		-HOVED 38-0501
STERLIN	IG PARK HEALTH CA	RECENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE CC	(X5) DMPLETION DATE
F 279	access site location and whom the facili unable to get to dia concerns. When interviewed of director of nursing v information on R45 regarding emergen access site was loc needed. No further informati 483.25 PROVIDE Of HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care.	no information regarding; h, checking bruit and thrill daily ty should contact, if R75 was lysis due to weather related on 01/11/13, at 9:50 a.m. the verified there was no dialysis 's and R75's care plan cy procedures, where the ated and any special cares ion was provided. CARE/SERVICES FOR	F 27	Completion date: February	QA e DNS. ed will be sed at the eting. At Committee nendation low-up 19, 2013 ving plan ncy does ot be nor an the truth usions prrection	7 of 45 7 of 45 7 29 2013 5 OVED 28 0391 3 000 3 000 3 000 3 000 3 000 3 000 3 000 00000000
	facility failed to coo failed to ensure sta	v and document review, the rdinate care with dialysis, and ff were aware of the necessary or 1 of 2 residents (R75) who sis.		executed solely because pr of state and federal law req Without waiving the foregoin statement, the facility states respect to: 1. Education provided on January 11, 201	ovisions uire it. ng with to RN-E 3,	
	R75 had diagnosis	of end stage renal disease -dialysis. The admission		regarding how to ch and thrill, and proce follow if not present Facility ID: 00843	edures to	

M'6MS-2567

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age 8 of 43 į.

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	TMENT OF HEALTH								FORM	: 01/29/2013) APPROVED . 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA	1 · ·	IULTII	PLE CONST	RUCTION		(X3) DATE S	
		2453	375	B. WI	NG				01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER				STR	EET ADDRE	ESS, CITY, STAT	E, ZIP CODE	ð	14942013
STERLIN	IG PARK HEALTH CA	RE CENTER			1		FIRST STREET RK, MN 5638			1391 1. (1391
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDEN SC IDENTIFYING INFO	BY FULL	id Pref Tac		(EA	PROVIDER'S PLA ACH CORRECTIVI SS-REFERENCED DEFIC	EACTION SHO	ULD BE	(X5) COMPLETION DATE
	Continued From pa minimum data set (identified R75 was of extensive assist wit (ADLs). During review of Ce Plan of Care, last up R75 access site was fistula]." R75's Dialysis Com 01/02/13, 01/07/13 access site was che (pulse) present by r was indicated as "r the question on the the bruit and thrill w to an off-site dialysi been completed by R75's care plan dat information regardin location, checking b the facility should co get to dialysis due to When interviewed of RN-E stated, she lis R75 since she leave shift and RN-E doct Communication Re dialysis unit and nu about 01/02/13, 01/ Communication Re the bruit and thrill w the bruit and thrill w	MDS) dated 12/2 cognitively intact, h activities of dail entra Care Kidney pdated on 01/07, s "AVF [arterial/ munication Reco and 01/09/13, inc ecked for bruit an egistered nurse (no". On 12/23/12, forms were not of rere present prior s unit. All five of t RN-E. ed 01/02/13, faile or dialysis access or uit and thrill dail ontact, if R75 wa o weather related on 01/11/13, at 6: stens for the bruit es for dialysis on uments on the Di cord which goes rsing home. RN-E 07/13 and 01/09/ cord and the forn ere not present. I , "the pulse and y lse by the access	and required ly living / Program /13, indicated /enous rd, dated dicated R75's id thrill RN)-E, which 12/28/12, completed if to transport he forms had ed to include s site y, or whom is unable to I concerns. 32 a.m. and thrill on the night alysis between the E was asked 13 Dialysis ns indicating RN-E stated /ou don't a site." RN-E	F	309	3. 4. 5.	Education to all nursing s 18, 2013, re procedures, tracking of to Procedure p track bruit a all residents dialysis. The DNS ar will complete for one mon audit weekly The data co presented to by the DNS. will be review the quarterly this time the make the decision/rec regarding ar	taff by Febr garding dial and daily oruit and thri out in place to nd thrill daily receiving ad/or her des to the data do the QA Co The data do ved/discuss QA meetin QA Commi ommendation by follow-up	uary ysis II. o y on signee weekly one nths. we mmittee collected ad at g. At ttee will on studies.	A C 45 A C 45
	verified staff did not					114 - 15 - c=+ ·			41 1	COSVOUS-
FORM CMS-28	567(02-99) Previous Versions	UDSOIETE	Event ID: 042V11		rac	ility ID: 0064	3	IT CONU	nualion shee	t Page 9 of 43

ACS AND COLONIC ON A NE COMPANY AND COMPANY AND A STATE

STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 66387 (x4) ju) SUMMARY STATEMENT OF DEFICIENCIES D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 9 PREFIX daily and only checked this on dialysis days. F 309 When interviewed on 01/11/13, at 9:38 a.m. F 309 icensed practical nurse (LPN)-B stated, she checks the access site for the bruit and thrill and indicates if it was present on the form. LPN-B did verify the bruit and thrill should be present to make sure the blood is flowing through the access site access site for the orbit and thrill and thill on dialysis days. When interviewed on 01/11/13, at 9:50 a.m. director of nursing was asked if the bruit and thrill should be present to make sure the blood is flowing through the access site access site for DON was uncertain if the bruit and thrill should be present when checking the access site should be present when checking the access site faction of the prevention	D PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET WAITE PARK, MM 56387 143 NORTH FIRST STREET WAITE PARK, MM 56387 143 NORTH FIRST STREET WAITE PARK, MM 56387 143 NORTH FIRST STREET WHen Interviewed on 01/11/13, at 9:58 a.m. 143 NORTH FIRST STREET Minoto Horizon and Horidi I Salton Coola II (hing he accees site PARK) 144 NORTH FIRST STREET <th></th> <th></th> <th>245375</th> <th>B. WING</th> <th></th> <th colspan="2">01/11/201</th>			245375	B. WING		01/11/201	
PREFIX TAG PECACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY Combine DEFICIENCY F 309 Continued From page 9 daily and only checked this on dialysis days. F 309 F 309 When interviewed on 01/11/13, at 9:36 a.m. licensed practical nurse (LPN)-B stated, she checks the access sile for the bruit and thrill and indicates if it was present on the form. LPN-B did verify the bruit and thrill should be present to make sure the blood is flowing through the access sile. LPN-B confirmed she would only check for bruit and thrill on dialysis days. When interviewed on 01/11/13, at 9:50 a.m. director of nursing was asked if the bruit and thrill should be present When checking the access site she replied, "I am unsure, I think 1 need to educate my staff." The DON was uncertain if the bruit and thrill needed to be checked daily. The facility's Dialysis (Renal) Internal Access Care Policy and Procedure, revised on 04/2011, indicated "Care of Internal Access (A V Fistula) daily checks [to feel for pulse (thrill) in the access. Listen with a stethoscope for the bruit (swooshing sound.) If pulse (thrill is absent, and bruit is inaudible, notify the physician and the dialysis unit." Although the facility was checking for the presence of the bruit and thrill on R75 on dialysis days, the facility failed to check it daily and to ensure staff were aware of the care for an AV fistula. F 314 No further information provided. F 314	TERLIN		ARE CENTER	14	2 NORTH FIRST STREET	·	
F 309 Continued From page 9 daily and only checked this on dialysis days. When interviewed on 01/11/13, at 9:38 a.m. licensed practical nurse (LPN)-B stated, she checks the access site for the bruit and thrill and indicates if it was present on the form. LPN-B did verify the bruit and thrill should be present to make sure the blood is flowing through the access site. LPN-B confirmed she would only check for bruit and thrill on dialysis days. When interviewed on 01/11/13, at 9:50 a.m. director of nursing was asked if the bruit and thrill should be present when checking the access site she replied, "I am unsure, I think I need to educate my staff." The DON was uncertain if the bruit and thrill needed to be checked dally. The facility's Dialysis (Renal) Internal Access (Care Policy and Procedure, revised on 04/2011, indicated "Care of Internal Access (A V Fistula) daily checks [to] feel for pulse (thrill) in the access. Listen with a stethoscope for the bruit (swooshing sound.) If pulse (thrill) in sten, and bruit is inaudible, notify the physician and the dialysis unit." Although the facility was checking for the presence of the bruit and thrill on R75 on dialysis days, the facility failed to check it daily and to ensure staff were aware of the care for an AV fistula. F 314 No further information provided. F 314 F 314 Ros Cyc) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES F 314	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	(X5) COMPLET DATE
Based on the comprehensive assessment of a	F 314 SS	daily and only check When interviewed of licensed practical in checks the access indicates if it was p verify the bruit and make sure the block access site. LPN-B check for bruit and When interviewed of director of nursing y should be present y bruit and thrill need The facility's Dialys Care Policy and Pre- indicated "Care of I daily checks [to] fee access. Listen with (swooshing sound.) bruit is inaudible, no dialysis unit." Although the facility fai ensure staff were a fistula. No further informati 483.25(c) TREATM PREVENT/HEAL P	ked this on dialysis days. on 01/11/13, at 9:38 a.m. hurse (LPN)-B stated, she site for the bruit and thrill and resent on the form. LPN- B did thrill should be present to od is flowing through the confirmed she would only thrill on dialysis days. on 01/11/13, at 9:50 a.m. was asked if the bruit and thrill when checking the access site insure, I think I need to The DON was uncertain if the led to be checked daily. is (Renal) Internal Access ocedure, revised on 04/2011, nternal Access (A V Fistula) el for pulse (thrill) in the a stethoscope for the bruit) If pulse (thrill is absent, and otify the physician and the it and thrill on R75 on dialysis led to check it daily and to ware of the care for an AV ion provided. IENT/SVCS TO 'RESSURE SORES				

		AND HUMAN SERVICES				FORM	01/29/20 APPROVE 0938-03
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S	URVEY ETED
-334		245375	B. WI	₩G		01/1	1/2013
	ROVIDER OR SUPPLIER	RECENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387		(AV) (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETIC DATE
F 314	who enters the facil does not develop p individual's clinical they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN by: Based on observat review, the facility fa on a weekly basis p residents (R63) in t pressure ulcer. Findings include: R63's diagnosis inc right heel. The quar dated 11/6/12, indic assistance with bed unstageable pressu by 9.0 by 0.1 centin ulcer care area ass indicated R63 had p planning would be o R63's wound care w 2:03 p.m., with RN- bed as slough, surn measured 5.5 cm x slough, and a Stage Review of progress	must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and from developing.	F	314	F 314 The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provision of state and federal law require Without waiving the foregoing statement, the facility states with respect to: 1. Residents # 63 has had reevaluation of his wounds, fact has consulted with the wound of Review and completion of comprehensive assessment, B scale and care plan updated. Dietary has reviewed diet. 2. Reviewed all residents with alterations in skin. Care plans I been reviewed, Weekly wound rounds have been reviewed. 3. Nursing staff education will the completed regarding wound pri- by February 18, 2013, 4. The DNS and/or her designed conduct two audits weekly for month and then once weekly for month and then once weekly for assessment and appropriate contact and plan.	does an truth ons ction sions it. h ility clinic. raden nave oe otocols ee will one or two er	20/20
	67(02-99) Previous Versions	Obsolete Event ID: 042V11		Fac	lity ID: 00643 If conti	nuation sheet	Page 11 of

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMPL	
		245375	A. BUIL B. WIN		G	01/	11/2013
	ROVIDER OR SUPPLIER	ARE CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387	0//	; 3420 ; 34200 ; 34
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
F.314	Dr. Hemming upda [name brand dress [treatment] book to The progress note: hospitalized on 11/ hospital until 11/16 discharge summar to his right heel wa debridement, and n admission to the he identified R63 was area and off loadin with wound care ar stay." The treatment included to: "Clear apply Santyl (a deb wound bed only, ca applied around wou Vaseline gauze, co kerlex. Apply Roya boot. Off-load area A review of R63's p weekly wound door discharge on 11/16 audit," each body a pressure ulcer, but characteristics. Th sheets identified dr surrounding skin co notes" identified the 11/21/12 "Heel has	heasuring 4 cm x [times] 4 cm. ated per fax. Applied an aleven sing] to the area and put in tx monitor." s indicated that R63 was 7/12 and remained in the /12. The 11/16/12 hospital y, indicated the pressure ulcer s infected, required surgical required antibiotics upon ospital. The discharge orders to "avoid pressure on heel g it will be important. Continue and boot as started this hospital int to right heel pressure ulcer nse area with wound cleaner, oriding ointment) applied to almoseptine (a protectant) und bed on intact skin. over with gauze, wrap with al (name brand) contracture a every 2 hours." progress notes, daily and umentation following hospital 6/12 included a weekly "body udit noted a right heel did not identify any wound e "Daily Wound Monitoring" ainage type, amount, olor, and pain. "Skin/wound e following: moderate amount of ugh present. Area around	F 3		5. The data collected will be pr to the QA Committee by the DN data collected will be reviewed/discussed at the quar meeting. At this time the QA C will make the decision/recomm regarding any follow-up studies Completion date: February 19, 20	IS. The terly QA ommittee endation s.	
l	37(02-99) Previous Versions	Obsolete Event ID: 042V11		l	ility ID: 00643	nuation sheet	<u>(((X))</u>

<u>JENTE</u>	<u>RS FOR MEDIC</u> ARI	E & MEDICAID SERVICES			OMB NO. 0938
ATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED
•••		245375	B. WING)	
AME:OF F	PROVIDER OR SUPPLIER		<u> </u>		01/11/201
· · ·	NG PARK HEALTH C	ARE CENTER		STREET ADDRESS, CITY, STATE, ZI 142 NORTH FIRST STREET WAITE PARK, MN 56387	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE COMPI THE APPROPRIATE DA
			1		
F 314	Continued From pa	age 12 of infection noted. Area is	F 31	4	
45- 46-5 校公	approx (approxima edges jagged. Mo	tely) 7 inches in diameter with derate amount of drainage asings when removed."			
HAN MAN	11/23/12 "Heel is a slough present. No has granulation pre Copious amount of	stage 3 Has yellow/white o necrotic tissue noted. Area esent in bed of the wound. sanguineous drainage or noted when dressing was			
<u>し</u> 表 	drainage noted on Had foul odor pres however, after clea Area has large amo thereabout wound wound bed is pink	nt of wound site is 8 cm in			
	11/29/12 "Moderate noted on old dressi	e amounts of serous drainage ng."			
192 ¹ 192	shift and there was serosanguineous d on heel appears to	dressing was changed this a small amount of rainage on old dressingArea be healing nicely and site an it has previously."			
	has granulation and amount of yellow/gr dressing. No s/sx o cm diameter, 2.25 o	ling/odor noted. Wound bed I slough present. Moderate reen drainage on removed of infection. Measurements: 4 cm length, 3.75 cm width. nout complications." There			

ATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE	CONSTRUCTION	(X3) DATE S COMPL	0. 0938-03 SURVEY
	of connection	IDENTIFICATION NOMBER.	A. BUIL	DING		COMPL	EIED
		245375	B. WIN	G		01/	1/2013
4	PROVIDER OR SUPPLIER	ARE CENTER		142 N	ADDRESS, CITY, STATE, ZIP CODE IORTH FIRST STREET TE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X6) COMPLET DATE
F'314		ige 13 n December, which was only	F 3	14			
	Small area on lowe present. Surroundi No signs of infectio in width, 2.25 in len	presents with granulation. r edge of wound has slough ng tissue is pink and intact. n noted. Measurements: 1.75 gth, 3 cm in diameter. Wound complication at this time."					29972 19972 1980
MALLAN This Martin Martin Martin Martin Stati	pressure ulcer size	consistently monitor the which included length, width, the pressure ulcer on a		an a			132
	was at risk for the c ulcers, but did not i pressure ulcer or w	ed 11/16/12 identified R63 levelopment of pressure dentify R63 had a current hat treatment should be urrent pressure ulcer.					X)) PES
	registered nurse (R ulcer was 8 inches odor on 11/7/12. Re came back with an wound clinic. RN-C documentation of w consistently monitor noted some nurses diameter, others do	1/9/13 at 2:21 p.m., N)-C stated R63's pressure in diameter and had a foul 3 went to the hospital and order for weekly visits to the verified weekly ound size had not been red on a weekly basis and document the wound in cument in length by width by only measures in diameter.					
tiga.	updated to include I A review of the facil	are plan had not been R63's current pressure ulcer. ity's Pressure Ulcer D/21/10, included under				:	
	87(02-99) Previous Versions	Obsolete Event ID: 042V11		Facility IC	D: 00643 If continu	ation sheet	Page 14 o
							5 18 5 18 10 1

		I AND HUMAN SERVICES				FORM): 01/29/2013 1 APPROVED). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			1	BURVEY
		245375	B. WI	NG_		01/	- 378 ∰ [1/2013 [/] 2833
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1	n Carton
STERLIN	NG PARK HEALTH CA				42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	'IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE (71)
F 314	prevention strategie guidelines, under lo Pressure Ulcers, "E stage (Stage I, II, II ulcer characteristic documenting the fo sizeexudatespa wound edges and s included, were guid how to stage a pres 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	ualized care plan addresses es" Also included in the lentification and Treatment of Describe the pressure ulcers I, or IV)Describe and monitor s weekly and as necessary llowing: location and staging, inwound beddescription of surrounding tissue" Also elines was a description of sure ulcer. F ACCIDENT		314	F 323 The preparation of the followi of correction for this deficience not constitute and should not interpreted as an admission m agreement by the facility of th of the facts alleged or conclus set forth in the statement of deficiencies. The plan of corr	y does be lor an e truth sions	14 of 4: 3 f (c.a. 3 f (c.a.)) 3 f (c.a. 3 f (c.a.)) 3 f (c.a.) 3 f (c.a.) 4 f (c.a.) 3 f (c.a.) 4
	by: Based on observat review, the facility fa assess and consist interventions for 1 c	IT is not met as evidenced ion, interview and document ailed to comprehensively ently implement fall f 1 residents, (R9) reviewed	· · · · ·		prepared for this deficiency w executed solely because prov of state and federal law requir Without waiving the foregoing statement, the facility states w respect to:	as 'isions 'e it.	- ε τη βαλη της - ε ξολογικής - τη ετηγλητίζη - τη ετηγλητίζη - τη της απόξηση - τη της απόξηση - τη της απόξηση
	with falls. Findings include:				 Resident # 9 a new fa analysis was complete 1/25/2013, and care p 	ed on Ian	73/2013 730VED
3. 3. 3. 2.4	diagnoses that inclu depression and anx Data Set (MDS) dat	the facility on 10/2012 with ide: urinary incontinence, iety. R9's admission Minimum ed 10/27/2012 included impairment and required			updated accordingly w current fall intervention new bowel and bladde assessment was also completed on 1/24/20	ns. A er	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 042V11]	Fac	ility ID: 00643 If continu	uation sheet	Page 15 of 43
							e de la comparte en date 13 e comparte

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		A. BUILDIN				
	<u></u>	245375	B. WING	· · · · · · · · · · · · · · · · · · ·	01/	1/2013.,.
iame of F	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	NG PARK HEALTH C	ARE CENTER		42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X6) COMPLETI DATE
F	living (ADL's). During observation was observed leav alarm was not attact the alarm was not attact the alarm was not attact the alarm should be and reattached TAI sweater. During continuous 8:15 a.m. to 10:12 room in her wheeld alarm was clipped reach of the reside the day room and a bedroom by license an insulin injection. back to the dayroot LPN-A and surveyd pressure sensor was sensor was not plut inoperable. At 9:40 participate in activit the dayroom until 1 started to stand up brought her to her n on for help. At 10:1 -A went into R9's ro bathroom. During interview on stated R9 went to the	ce of staff for activities of daily on 1/9/2013 at 12:51 p.m., R9 ing the dining room, her TABS ched to the resident shirt and ging off her wheelchair. Sing assistant (NA)-D stated e attached to R9 at all times BS alarm to the back of R9's observation on 1/10/13, from a.m. R9 was in the dining shair eating breakfast. The tab to the back of her shirt within nt. At 8:35 a.m., R9 wheeled to at 8:38 a.m., R9 was brought to ed practical nurse (LPN)-A for At 8:40 a.m., R9 was brought m to watch TV. At 8:41 a.m. or observed R9's bed, a as between the sheets, but the gged into the wall, making it a.m. R9 continued to ites and watched television in 0:10 a.m. At that time R9 and the activities director room and turned the call light 2 a.m. nursing assistant (NA) bom and assisted her to the	F 323	 Staff care sheets have updated to reflect cur fall interventions and toileting schedule. Efficility fall will be eval for correlation to toile schedule and review the IDT Education regarding sheet updating and palarm placement will provided by Februar 2013 The DNS and/or held designee will complet audits per week for comonth then weekly for months. The data collected will prevented to the QA Committee by the DI The data collected will reviewed/discussed quarterly QA meeting this time the QA Corwill make the decision/recommence regarding any follow studies. Date of Completion: Februar 2013 	rrent ach iluated eting ed by care proper be y 18, ite two one or two ill be at the s. ill be at the g. At nmittee lation up	
	stated R9 was to be is kept track on the	e toileted every 2 hours which computer. She was unsure of oileted and checked the				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		245375	B. WIN	1G		01/11/2013		
	ROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE, ZIP CODE NORTH FIRST STREET NTE PARK, MN 56387		24 24 2031	
(X4) İD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F.323	9:52 a.m., 20 minut 10:12 a.m. NA-A wa continuously observe the bathroom during did not take R9 to the had been charting in was unsure the last the bathroom. During interview on stated she toilets R9 after meals, when we and when she puts interview on 1/11/13 works nights and ge night and we check a.m., 2:00 a.m. and sometimes she tries alarm sounds so we Review of the progra	ted R9 was last toileted at es before R9 was toileted at as informed that R9 was yed and had not been taken to g that time. NA-A stated she he bathroom at that time, but n R9 electronic record. She time R9 had been taken to 1/10/13 at 2:26 p.m. NA-B, 9 every 2-3 hours, before and ye get her up and lay her down her call light on. During 8 at 7:03 a.m. NA-C, stated he ets R9 up about 3-4 times a her at rounds, which is 12:00 4:00 a.mNA-C also stated, as to get up herself, and the e toilet her at that time also. ess notes indicated R9 had sion to the facility from		323			To of the To of the To of the test of the test of test	
	10/26/12 through 12 identified the followi On 10/26/12, R9 wa next to her bed at 1: trying to get to the to the interventions of	2/25/12. The progress notes ng: s found on the floor by staff 55 a.m., R9 stated she was bilet. The facility implemented frequent toileting, call light						
	On 10/31/12, R9 wa mat next to bed at 8 implemented were to light and staff to toile	ucation to use the call light. s found by staff on her floor :50 p.m. The interventions o remind resident to use call et her every 1.5 hours. found on floor by staff in her					Add Si DVE Si Date Si	

		AND HUMAN SERVICES				FORM	: 01/29/20 APPROVI
TATEMEN	RSFOR MEDICARE	& MEDICAID SERVICES	(X2) N	AUL	TIPLE CONSTRUCTION	(X3) DATE S	0938-03
243 - 1 41, 7			A. BU	ILDI	ING	COMPL	EIED
ian Tite		245375	B. WI	NG _		01/1	1/2013
NAME OF F	PROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000	112010
STERLIN	IG PARK HEALTH CA	ARE CENTER			142 NORTH FIRST STREET WAITE PARK, MN 56387		
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F 323	Continued From pa	ogo 17	-				AN 17.0
	bathroom at 7:15 p	.m. The interventions led a pad sensor in R9's bed.	F.	323	3		
NA -	floor mat next to he was sounding, but l safety alarm (TABS	as found on by staff on her r bed at 5:00 a.m. The alarm R9 had removed her personal i) alarm and was placed back ntions implemented were bed					1128.0 11728.0 11729/20
	in lowest position, o	all light in reach of resident, while R9 was in bed.					1:FOV
1 L J	at 5:15 a.m She to	as found on her floor by staff Id staff she was trying to use nad removed the tabs alarm.					
	The interventions in closer to the nursing regarding frequency pharmacy reviewed	nplemented were to move R9 g station, re-educate staff y of toileting at night and medications which were tributing factor to the falls.					()3 ()3 ()3 ()3 ()3 ()3 ()3 ()3 ()3 ()3
	mat next to her bed was trying to get to not connected and t plugged into the wa	as found by staff on her floor at 1:15 a.m The resident bathroom, TABS alarm was he sensor pad was not II, making it inoperable. The nented were to re-educate					1981E 1981 1995 1995 1995 1995 1995 1995 1995
	staff on the placeme On 12/17/12, R9 wa	ent of the TABS alarm. Is found by staff on her floor				. :	
	mat next to her bed stated she needed t staff verified they ha shift. The interventio	at 4:40 p.m The resident o use the bathroom and the id not toileted R9 yet that ons implemented were to on the use of TABS alarm			-	•	
	On 12/19/12, R9 wa to her bed at 9:55 a.	s found on floor by staff next m. and the TABS alarm was					
A CMS-256	7(02-99) Previous Versions	Obsolete Event ID: 042V11		Fac	cility ID: 00643 If contin	uation sheet F	
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		H AND HUMAN SERVICES				FORM	: 01/29/20 APPROV . 0938-03
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∑ 4.		245375	B. WI	۹G		01/4	1/2013
	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1720,13 ₅₅₇
stérlin	G PARK HEALTH C	ARE CENTER		142	NORTH FIRST STREET		
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F 323	Continued From pa	200 18					
	not attached to resincluded to re-educ	ident. The interventions cate the resident on the use of emind not to remove the TABS	F.	323			1999 1994 - 14 1947 - 14 1947 - 14
	by her bed at 4:40	vas found by staff on the floor p.m. The interventions to remind the resident to use				ء • • •	ว:/29/20 ว:/29/20 วะหรอบ วะรูB-03
·	bathroom floor at 8 sounding. The inte	ras found by staff on her 3:15 a.m. with her TABS alarm rventions implemented was to alarm to R9's shirt.					1.224.44 577 577
NAL NAL	dining room at 2:30 her wheelchair and to her sweater but The interventions in	as found by staff on the floor in 0 p.m She had slipped out of I the TABS alarm was attached R9 had removed her sweater. mplemented were to make rm was on R9 and working.					
	falls. Four of the 1 shift between 1:15 were in the evening p.m. All of these 8 her room next to he There was only 3 o shift, and 2 of these room or bathroom.	identified R9 had a pattern of 1 falls were during the night am and 5:15 a.m.; 4 of 11 falls between 4:40 p.m. and 8:50 falls, identified R9 was either in er bed or in the bathroom. f the 11 falls during the day e 3 falls were in the residents There was only one fall, in ed out of her wheelchair.				:	150 194 194 194 194 194 194 194 194 194 194
	Review of facility F 10/20/12, indicated impairment, hearing balance problems	all Risk Analysis dated resident had vision, g loss and sensory loss, with standing and walking, akness and needs toilet				· · ·	/930003 16 Å
	7(02-99) Previous Versions			Facility	ID: 00643 If contin	uation sheet I	9ane 10 4
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		AND HUMAN SERVICES			FOR	D: 01/29/2013 M APPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE	
		245375	B. WIN	IG	01/	11/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
STERLIN	NG PARK HEALTH CA	RECENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		*//29/26#3 **ROVED
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F323	recent falls in past r related to health cor balance and weakn falls since the 10/20 comprehensive fall was a pattern of fall interventions could R9 risk of falling. Review of R9's care identified the proble toilet the resident ev pad sensor while in lunch and supper at resident uses her can not always know wh plan did not address During interview on director of nursing r they placed a variet included toileting, se dycemen in her whe slippery, moving her and having the phar medications to dete related to her falls. tabs alarms were ap continues to remove say since moving R and using the dycen decreased and ackr reminding R9 to use appropriate.	sessment indicated R9 had month and previous falls ndition with dizziness, loss of ess. Although R9 had multiple 0/12 analysis, there was no assessment to identify if there is to determine which be effective to help decrease e plan, last updated 11/26/12, m of falls and directed staff to very 1.5 hours, use pressure bed, ambulate the resident to nd toilet to prevent falls. The all light minimally, and does nat the call light is. The care is the use of a TABS alarm. 1/10/13 at 3:15 p.m. the eviewed R9 falls and stated y of interventions which ensor pads, tabs alarm, using pelchair so it wasn't as r closer to the nursing station macist review her rmine if medication could be The DON was unsure if the opropriate for R9 since she is the device. She went on to 9 closer to the nursing station	F 3			19.013 5-0300 5-030 5-00
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 042V11		Facility ID: 00643	f continuation sheet	Page 20 of 43

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION		OMB NO (X3) DATE S COMPLE	. 0938-039 URVEY ETED
		245375	B. WIN	G		-	04/4	1/2013
	ROVIDER OR SUPPLIER		_ <u>_</u>	STREET AD	DRESS, CITY, STATE, ZIP		01/1	1/2010/07 2008
STERLIN	G PARK HEALTH CA	RECENTER		142 NOR	TH FIRST STREET PARK, MN 56387	UUDL		د بر المحمد من المحمد المح المحمد المحمد br>المحمد المحمد
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI ROSS-REFERENCED TO TI DEFICIENC)	ion shou He appro	LD BE	(X5) COMPLETIO DATE
1000年 1005 1005 10	determine an appro R9 during these tim varied from every 1 to before and after to get up from her of be toileted timely and she needed to use alarm and sensor p applied to reduce R was identified as an R9's falls were not of determine appropria reduce the risk of fa interventions consis No further informati 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in of duplicate therapy); without adequate m indications for its us adverse consequent should be reduced of combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and d record; and residen	dentify this pattern to opriate toileting schedule for les. R9's toileting schedule .5 hours, to every 2-3 hours, meals or when she attempts shair. R9 was observed not to nd attempted to stand when the bathroom. Also R9's ads were not consistently 9 risk of falls even though this n intervention by the facility. comprehensively assessed to ate interventions to help alling nor was the facilities fall stently implemented. on was provided. EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of icces which indicate the dose or discontinued; or any	F 3:	F 329 29 The of content of content agree of the set for defice prep exect of st With state resp	preparation of the fol prection for this defic constitute and should preted as an admissi ement by the facility e facts alleged or cor orth in the statement ciencies. The plan of pared for this deficien- cuted solely because tate and federal law mout waiving the foreg ement, the facility state pect to: 1. Resident #24, no pharmacological interventions ador sheet. Medication was reviewed by C	iency de not be ion nor a of the tr nclusion cof f correct cy was provisio require if going ites with con- ded to c n regime	oes an ,. uth is ion ons t. n	
					Pharmacists			- 4. <u>G.G</u>
	7(02-99) Previous Versions	Obsolete Event ID: 042V11		Facility ID: 00	0643	If continua	ation sheet I	Page 21 of
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		AND HUMAN SERVICES				FORM	01/29/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONST .DING	RUCTION		URVEY
. •		245375	B. WIN	G		01/1	1/2013
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F.329	contraindicated, in a drugs. This REQUIREMEN by: Based on interview facility failed to mon prescribed for 2 of 1 R43)who were revie medications. Furthe ensure ongoing just 1 of 10 residents (R unnecessary medic R24 received as ser medication was not R24 diagnoses incl disease (currently re dementia with behar and depression. The data set (MDS), date cognition was not at inattention and diso Psychotropic Drug U (CAA), not dated, in Remeron (anti-depre Seroquel (anti-psych behavioral disturbar reductions had beer seroquel had recent	AT is not met as evidenced and document review the itor efficacy of medications 10 residents (R24 and ewed for unnecessary rmore, the facility failed to ification of medication use for 57) who were reviewed for ations. roquel and the efficacy of this consistently monitored. uded stage Alzheimer's ecciving Hospice benefit), vioral disturbances, anxiety e significant change minimum ed 10/16/12, indicated R24's ble to be screened, and had rganized thinking. The Jse Care Area Assessment dicated R24 was receiving essant) for depression and notic) for dementia with ice. The CAA indicated dose in made in the past, the ly been increased while at a sychiatric unit, and R24 was	F 3	3. 4. 5.	medication regimen revie by Consultant Pharmacia February 7, 2013. Staff will be educated procedure for PRN use and documentation, in addition to using non pharmacological interventions prior to administering the PRN February 18, 2013. The DNS or designee complete two audits po week for one month and then one audit per weat two months on PRN use	st on on age I, by er nd ek for sage be collected ssed at ing. At nittee will tion p studies.	1/29/2013 PROVED P20/2013 PROVED P23 0391 P25 00
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 042V11

Facility ID: 00643

If continuation sheet Page 22 of 43

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	MENT OF HEALTH	AND HUMAN SERVICES					: 01/29/2013
		& MEDICAID SERVICES					APPROVED 1 . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		245375	B. WIN	{G		01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	2-0391
STERLIN	IG PARK HEALTH CA	RECENTER		1	42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F. 329	Continued From pa	ge 22	F	329			12 AM
	the following: Rema bedtime for depress day for aggressive misperceptions, and	lers dated 12/21/12 included eron 22.5 milligrams (mg) at sion, Seroquel 75 mg twice a physical/verbal behaviors and d Seroquel 25 mg twice a day					
	behaviors, or mispe						29/2013 332005D 333-0391
je K	R24 received the "a occasions between review of the "as ne the 8 dosing's were physical and/or veri was documented at the "Result" section on 2 dosing: 10/24/	dministration records (MARs), as needed" Seroquel on 8 10/18/12 and 11/14/12. In beded follow up charting", 7 of given for some form of cal aggression. The 8th dose t "states she feels anxious". In staff had only documented 12 "not effective" and 11/12/12					22102013 22102013 221034459 200351
	up on. R24's nursing progr	r doses had not been followed ress notes associated with the iew and the following was					
	grab nursing assista nursing assistant. R needed" Seroquel p	n. "Resident proceeded to ant by the hair and scratch Resident was given "as per doctors orders for , there was no documentation al interventions.					LUCK
	out for an hour after evening. When staf resident was unable continue to monitor	n. "Resident continued to yell r she was laid in bed this f asked her what she needed, e to answer. Nursing will resident and her behavior." s no documentation of					1 <u>26-0391</u>
FORM CMS-26	67(02-99) Previous Versions	Obsolete Event ID: 042V11		Fac	cility ID: 00643 If contin	uation sheet	Page 23 of 43

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		AND HUMAN SERVICES				FORM	01/29/2013 APPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES	(Y0) M		PLE CONSTRUCTION	(X3) DATE S	0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			COMPLE	
241		245375	B. WIN	IG		01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		noka) EVéan-
STERLIN	IG PARK HEALTH CA	RE CENTER			12 NORTH FIRST STREET /AITE PARK, MN 56387		3039
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From pa Seroquel being give interventions.	ige 23 en or other non-pharmological	F 3	329			11397
	10/26/12 given twic "Resident did scrate	e at 1:35 p.m. and 4:00 p.m. ch daughter, when daughter nt from hitting another					in the form
	resident." The staff day, while they had checks, there was needed" Seroquel v	documented twice more that placed resident on 15 minute no documentation that the "as was given until the last entry at					3 -17 -39/201 -30V51 -30V51 -309
	-	on-pharmological tried prior to given Seroquel.					
	given after redirecti	m. "As needed Seroquel was on and multiple attempts at behavior did not work. Resident bed at this time."		وتوجو وحدادي ومادلة وعاديات والمالية فالمالة ماليا معالماتهم والمالية			10425 1446 1499 1499 1499 1499
	the butt and was wa most of shift. As ne parameters but was	m. "Resident slapped nurse on andering throughout the halls eded Seroquel was given per s not effective for behaviors. yelling at nurse and other					JOMPIETON DATE DATE DATE DATE DATE DATE
interna Di Alt Alt Alt Alt Alt Alt Alt Alt Alt Alt	residents., but when there was a problem out at the nurse/sta monitor." Furthermo documentation of n	n asked what she needed or if n she would say no and swat ff. Nursing will continue to ore, there was no on-pharmological					
	11/12/12 at 1:05 p.r charting" document Seroquel was "slap	tried prior to given Seroquel. n. The "as needed follow up ed the reason for giving ped other resident shoulder." onic progress notes indicated				Ţ	1972013 NOVED
- - 	only, "resident has I halls this shift. Resi	been wandering around the dent was making faces and dents this evening, but staff					tap SZOR
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 042V11		Faci	lity ID: 00643 If contin	uation sheet I	Page 24 of z

at Page 24 of 43

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	TMENT OF HEALTH						FORM): 01/29/2013 1 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER	D SERVICES VSUPPLIER/CLIA ATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION		0. 0938-0391 SURVEY ETED
			245375	B. WIN	IG _	· · · · · · · · · · · ·		140040
NAME OF P	PROVIDER OR SUPPLIER		240370		STE	REET ADDRESS, CITY, STATE, ZIP CODE	01/1	11/2013
1.	IG PARK HEALTH CA	ARE CENTER		1	1	42 NORTH FIRST STREET WAITE PARK, MN 56387		1 (1391
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
			······································	·				3.0/60
F.329	Continued From pa	-		F 3	329			1100分前推
	separated the resid	iems.						1854 1954 1954 August
	11/14/12 at 1:35 p.i behaviors noted thi							Contraction Contraction
	felt anxious and dic							م می و می اور می اور می اور می و می
	seroquel. She is re	sting at this ti	me."					
P.F.J.	R24's care plan dat	ted 1/26/11 in	cluded a problem					- //29/2013
1	for Behaviors indica			1				-SR-0391
lan Harte	demonstrate physic grabbing) towards :			:				
	were directed to re-			I				Constant A Sala
	provide appropriate intervene before ag							- Sugar
Ξ^{a}	calmly in conversat	tion, and if res	sident is	i				0.3VC
and the State of the Antiparty of the state	aggressive, staff wa re-approach at a la		ay and	l				- 0393
-4) 45 -4 7 6 	On 01/11/13 at 8:30 -B stated the facility indications of non-p the appropriate use	y's documenta pharmological	ation lacked I interventions, or	i				(XS) -26491 F10N -20491 F10N -20495 - 204 -20495 - 204 -2040 -20495 - 204 -20495 - 204 -2045 - 204 -204 -2045 - 204 -2045 - 2045 - 204 -2045 - 2045
	No further informat							
	R43's received Vico	odin (a narcot	tic pain reliever)					\$5) 1 + 1, <u>177</u> 8,28
	as needed for pain.	. The medicat	tion was not					artika a La sejantika
	adequately monitor medication was effe		ne if the					ى يەلەللەن ئەلىكى بىلىغۇن ئەلىرىغى بىلىغۇن يېلىغۇن ئەلىرىغى ئەلىكى بىلىغۇن ئەلىكى بىلىغۇن ئەلىكى بىلىغۇن ئەلىك ئەلىقى ئەلىكى
-					ļ			
B.s.	R43's diagnoses in osteoarthritis and o							
<u>8</u>	minimum data set ((MDŚ) dated [.]	12/20/2012					6.0391
54 13	indicated moderate required extensive				!			
	activities of daily liv							
2000 2000 2000	R43's physician's o	rders dated 1	1/26/2012					가만한 1년 27년 년
	67(02-99) Previous Versions	Obsolete	Event ID: 042V11		Fac	cility ID: 00643 If contin	uation sheet	Page 25 of 43
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1.372 2.272								29410000N 1730, 4
i National Anti-								N State
								n ne ne dese

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/29/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION		URVEY
		245375	B. WI	NG_		01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER	1	····	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	0391
STERLIN	IG PARK HEALTH CA	ARE CENTER		1	142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΠX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From pa included: Hydrocod 1 tab every 4 hours musculoskeletal pa	one APAP (Vicodin) 5/325 mg, as needed for	F	329			
	11/26/2012 through received 33 doses The PRN Follow Up through 1/6/2013 in 4 out of 33 times be blank. The progress through 1/8/13, only PRN Vicodin was e	Administration Record dated 1/8/2013, indicated R43 of prn (as needed) Vicodin. Charting, dated 11/26/2012 idicated Vicodin was identified bing effective. The rest were s notes dated 10/23/12 y identified on 12/16/12, the iffective, there were no other ed R43 pain and if the ective.					01/20/2013 PPROVED 1938-0391 411 012/2013 012/2013 012/460
	licensed practical n charts the effective up sheet under res She was unsure wh	1/10/13 at 2:46 p.m. with urse (LPN)-D, stated she ness of pain in the prn follow ults after an hour and or two. ny this was not being nented to determine if the active.					15 YION 1401 - 45 15 OF 45 25 OF 45
	registered nurse (R documenting on the the pain medication						20 20 20 20 20 20 20 20 20 20 20 20 20 2
	consultant pharmac staff need to be foll	1/11/13 at 9:40 a.m. with the cist (Pharm-D), stated that owing up on the results of administering prn Vicodin					920-0381
	A facility policy entit	led PRN Medications dated					
ORM.CMS-25	87(02-99) Previous Versions	Obsolete Event ID: 042V11		Fa	cility ID: 00643 If contin	uation sheet	Page 26 of 43
143 143 12 12 14 14 14 14 14 14 14 14							
							20 (27 14, 1 2, 20 (27 14, 1))))))))))))))))))))))))))))))))))

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DEDAD							: 01/29/2013
-		AND HUMAN SERVICES					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M		PLE CONSTRUCTION	(X3) DATE S	. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU			COMPLI	
							1997 - 1997 -
		245375	B, WI	1G		01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		0.739/2013
STERLIN	IG PARK HEALTH CA	RECENTER			42 NORTH FIRST STREET		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
				V	VAITE PARK, MN 56387		
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREF	v	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPE		DATE
	······				DEFICIENCY)		1.000
F 000							1.1392
F-329	Continued From pa	-	F	329			25 6F4:
···· .	i tone in to, intoladou,	"If prn meds are needed, resident's condition must be					
say: Stric		administration." The policy also					5 I.S.
<i>.</i>		ds are to be documented on					"我要
, 	the "PRN medication	n follow-up sheet" which is					11 - 44747
		The follow-up sheet is to be					(Sar
		ts so appropriate follow-up on medication is completed."					-1/29/2013
:RA:		medication is completed.					- CROVED
- MT -	No further informati	on was provided.					133.0391
1		-					t diadesi.
		epressant and anti-anxiety					
	these medications without	t justification for the use of				.,	2013 1-2013
5	inese medications a	at the current dose.					- CH2013
	R57 diagnoses inclu	uded depression, anxiety and					- NROVED
, •		annual minimum data set				·.	<u>1. 1. 0391</u>
		/12, indicated R75 was					i a calendarian (X)
k. Ast		epressant and anti-anxiety ognitively intact. The					SATE SATE
		Use Care Area Assessment					114/0-2
	(CAA), dated 11/27	/12, indicated only the				•	ىيىتىتىتىيەت ئەتتىت ، ئوگ
		has a history of and					مد هد رود
		ssion, he is not displaying at this time. He states that his					25 51 41
•••• •••		nanaged and that he feels					Tarihi (
	good. No concerns						A State
-							19.00
		ers dated 12/21/12 included					- 172(1) - 1747年 - 1747年
: 1	(mg) twice a day for	r medication) 5 milligrams					1/20/2012
1773.		.5 mg every bedtime for					- WWW.
	depression, Zoloft 5	0 mg (antidepressant /					1 39-0391
		pedtime for panic attacks and					
		eizure medication sometimes					a la sur ance
÷ .	anxiety.	mg twice a day as needed for					
	sincey.			Ì			1.013
		· · · · · · · · · · · · · · · · · · ·		ĺ			NEGM/SH1
ODM OMO OF	67(02.00) Bravious Varsions	Obsolate Event ID: 0421/11		Eas	libr ID: 00643	untion about	Dono 27 6442

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 042V11

Facility ID: 00643

If continuation sheet Page 27:0f:43

			(70)	at 11 11 1	DIE CONSTRUCTION		. 0938-039
	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MUL III JILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	ETED
9		245375	B. WI	ING		01/1	2.9901 1/20133/GI
NAMÉ OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CO		5439
STERLIN	IG PARK HEALTH CA	ARE CENTER		1	42 NORTH FIRST STREET /AITE PARK, MN 56387		an a san br>San a san
(X4) ID		ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TÀG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE O
F 329	Continued From pa	27		329			-00 200H2
		ted 12/13/12 included use of	r	329			U AN ERION
		antianxiety medications.					C (R).
	D571a navahistristu	progress notes dated 11/1/12,					- set spa
•		R57's anxiety was stable, to					
	continue the currer	nt medications and would be					1.18
ф.		However, in review of the list progress notes, dated					21201
di d	11/28/12, the notes	s indicated R57 continued to					OVE
. 1		hich caused anxiety and the					
ж.		to continue to explore ways ore realistic expectations of					1.1.1.1.1
11. a. f. 1	himself and others	. The notes failed to address					
	ongoing need for a medications at the	ntianxiety, or antidepressant r current doses.	ļ	-			11/6211 2010
35 J -	During interview or	n 01/11/13 at 8:30 a.m., a			F356		
 1 :	registered nurse-X	verified that ongoing	İ	-	The preparation of the follo	wing plan	0.51
Pe 2	medication was lac	cking for R57's psychotropic			of correction for this deficie	ency does	》。新月1100 975年
F 356	483.30(e) POSTEI	NURSE STAFFING	F	356	not constitute and should r	not be	
SS=C	INFORMATION				interpreted as an admissio agreement by the facility o		
	The facility must p	ost the following information on			of the facts alleged or cond		
	a daily basis:	•			set forth in the statement of		- 4.2 (31) - 495
	o Facility name. o The current date				deficiencies. The plan of c prepared for this deficienc		ىيىنى ئەلەر ئېيىنى ئەلەر
e de la composición de la comp		and the actual hours worked			executed solely because p	provisions	
-		tegories of licensed and			of state and federal law re-		1.1.4
а. н. н. 1 г.	resident care per s	staff directly responsible for hift:			Without waiving the forego statement, the facility state		19/201
*	 Registered nu 	Irses.			respect to:		949) 5-4520
-		ctical nurses or licensed as defined under State law).			1. Medical Records will create posting		<u>1939</u>
	- Certified nurs				post daily	, mgnit i tra ann	
•	o Resident census				2. Audits will be done		18026
	The facility must pr	ost the nurse staffing data			weeks, than week months	ly for two	10V5 919
44+ 			<u> </u>			· ·····	
M CMS-28	567(02-99) Previous Version	s Obsolete Event ID: 042V	11	Fac	sility ID: 00643	continuation sheet	Page 28 of 4
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•							المربعين المربعين مربع المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعي محمد المحمد المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين المربعين
•							99 (2 4)
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		I AND HUMAN SERVICES				PRINTED: FORM	01/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		245375	B. W	NG_		01/1	1/2013 (inter-
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	ARE CENTER			VAITE PARK, MN 56387		· 1945年
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TA	"IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 356	of each shift. Data o Clear and readat o In a prominent pl residents and visito The facility must, u make nurse staffin	a daily basis at the beginning must be posted as follows: ole format. ace readily accessible to		356	3. The data collected will presented to the QA C by the Dietary Manage data collected will be reviewed/discussed at quarterly QA meeting. time the QA Committe make the decision/recommendal regarding any follow-u	ommittee r. The the At this e will tion	28 of 4: 28 of 4: 20/2013 20/2013 20/2013 20/2013
1. (1.) (1.) (1.)	staffing data for a r	aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.			Completion date: February 19, 2	013	
	by: Based on observa review the facility f staffing information potential to affect t	NT is not met as evidenced tion, interview and document ailed to post the required nurs n on a daily basis. This had the he 44 residents currently ity, and any visitors.	e e				
1000 - 1000 1000 - 1000 1000 - 1000 1000 - 1000 1000 - 1000	Findings include:						
- -	11:55 a.m., the dai a bulletin board ou	ur observation on 1/8/13 at ly staff posting was hanging o tside the nurse's station. The osting was 12/14/12, 25 days	n				A STREET
	of nursing (DON) was 25 days old, d stated the medical responsible for upo	n 1/8/13 at 11:55 a.m., directo rerified the current staff postin ated 12/14/12. The DON records person was dating the staff posting daily, cal records person resigned a	g				
FORM CMS-2	567(02-99) Previous Version		<u> </u>	Fa	acility ID: 00643 If conti	nuation sheet	Page 29 of 4
1000							
						. •	2 37.2 1. 1.3 A 4

		H AND HUMAN SERVICES E & MEDICAID SERVICES				PRINTED: FORM OMB NO.	APPROVE
TATÈMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SI COMPLE	
		245375	B. WIN	G	·	01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER		I.	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH C	ARE CENTER			NORTH FIRST STREET ITE PARK, MN 56387		4.93
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
					· · · · · · · · · · · · · · · · · · ·		2.
F_356		ecember. DON stated no one d to ensure the staff posting of	F	56			
1971	postings since 12/					-	1972 1972 19972(
F:371 SS=F	No further informa 483.35(i) FOOD P STORE/PREPARE		F 3	571	F 371	 	
	considered satisfa authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions			The preparation of the follow of correction for this deficier not constitute and should no interpreted as an admission agreement by the facility of of the facts alleged or concl set forth in the statement of	ncy does ot be nor an the truth usions	
	by: Based on observa review, the facility was done in a san spread of food bor	NT is not met as evidenced ation, interview and document failed to ensure food service tary manner to prevent the ne illness. This had the all 44 residents currently ity.			deficiencies. The plan of co prepared for this deficiency executed solely because pro of state and federal law requires Without waiving the foregoin statement, the facility states respect to: 1. Dietary staff were e on proper glove use January 17, 2013	was ovisions uire it. ng with ducated	
	observed touching gloved hands and	e observation, Cook-A was multiple surfaces with dirty then picking up plates and iging her soiled gloves.			 The DOD and/or he designee will compl audits per week for month than 2 audits for two months on rastaff. 	ete 5 one a week	
₹M GMS-25	67(02-99) Previous Version	s Obsolate Event ID: 042V11		Facility	ID: 00643 If continu	ation sheet F	age 30'of
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						-	
							1. 10 10 10 10

	F DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245375	B. WIN	G	01	ಿದೆ. /11/2013ಿಕ್
2	DVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 142 NORTH FIRST STREET WAITE PARK, MN 56387		5 F A E 12 (33 12 (13)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
LOssthhOthiraAti g1 w1is gw Lssss LdirspLassa DR	Cook-A was observ surface of plates, to hen picking up brea hand and placing br Cook-A brought a tr he refrigerator with in refrigerator. Cook offer touching the tr At 12:07 p.m., Cook-A intes to pick up a si ploves and place the 2:11 p.m., Cook-A vith gloved hands a 2:15 p.m., Cook-A s placed and touch- ploves. Cook-A con vithout first changin During interview on tated she put glove serving and does no serving. During interview on tated she put glove serving. During interview on tated that is cross-co cheduled next Thu anitation; I have ha bout proper glove of Die Responsibilities date	on 1/8/13 at 12:05 p.m., red picking up and touching buching handles to serve food, ad with her soiled gloved right read on plate. At 12:06 p.m., ray to the refrigerator, opened gloved hand and placed tray c-A did not change gloves ay and the refrigerator handle. c-A was observed multiple lice of bread with soiled e bread on the plates. At opened the refrigerator door and removed the butter. At picked up plates where food ed bread with her soiled tinued this same process ag her soiled gloves. 1/8/13 at 12:20 p.m. Cook-A, es on right before she started of change her gloves during 1/11/13 at 7:55 a.m. with the DOD)-D, stated that it was bok-A to touch multiple ring gloves and then pick up n the same soiled gloves. was not acceptable practice ntamination. I have a meeting rsday on glove usage and ad to talk to some people use.	F 3	 3. The data collect presented to the Committee by th The data collecte reviewed/discuss quarterly QA mentify this time the QA will make the decision/recomming regarding any foll studies. Completion date: February 	QA e DOD, ed will be sed at the eting. At Committee endation ow-up	2. 30.81 2. 201 2. 2

		AND HUMAN SERVICES	8				: 01/29/20 I APPROV . 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTR	RUCTION	(X3) DATE S COMPL	URVEY
		245375	B. WIN	G		01/1	1/2013
12	ROVIDER OR SUPPLIER G PARK HEALTH CA	RECENTER		142 NORTH F	SS, CITY, STATE, ZIP CODE FIRST STREET SK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	< (EAC	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLET DATE
F-425 SS=D P. 1 N.C. P. A. P. A. M.C. M.C. M.C. M.C. M.C. M.C. M.C. M.	required to wash habetween tasks. No Further informa 483.60(a),(b) PHAF ACCURATE PROC The facility must pro- drugs and biologica them under an agre §483.75(h) of this p unlicensed person law permits, but on supervision of a lice A facility must provi (including procedur acquiring, receiving administering of all the needs of each r The facility must en a licensed pharmac on all aspects of the services in the facility by: Based on observat interview, the facility medication patches manufacturer's inst	and all employees will be ands as frequently as needed tion was provided. RMACEUTICAL SVC - EDURES, RPH ovide routine and emergency ils to its residents, or obtain eement described in art. The facility may permit rel to administer drugs if State y under the general ensed nurse. de pharmaceutical services es that assure the accurate , dispensing, and drugs and biologicals) to meet esident. nploy or obtain the services of ist who provides consultation e provision of pharmacy	F 3	25 The pre of corre not con interpre agreem the fact forth in The pla this def becaus federal the fore	425 eparation of the followin ection for this deficiency stitute and should not be deted as an admission not hent by the facility of the salleged or conclusion the statement of deficit an of correction prepare ficiency was executed as be provisions of state ar law require it. Without egoing statement, the fa- with respect to: All nursing staff were immediately educated facility policy and pro- We will review this ed with all nursing staff k February 18, 2013. The DNS or designed 2 audits per week for month, and then 1 au weekly for 2 months compliance.	does be or an e truth of is set encies. d for solely nd waiving acility d on cedure. lucation by e will do 1	13.2 14.2 15.2
M CMS-256	97(02-99) Previous Versions	Obsolete Event ID: 042V11		Facility ID: 00643	lf contin	uation sheet	Page 32 o
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		AND HUMAN SERVICES				FORM): 01/29/2013 1 APPROVED
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Ĵ ₇		245375	B. WI	NG _		01/	1/2013
NAME OF P	ROVIDER OR SUPPLIER			sr	REET ADDRESS, CITY, STATE, ZIP CODE	01/	11/2013 1/2013 1/2013
STÉRLIN	IG PARK HEALTH CA	RE CENTER		1	142 NORTH FIRST STREET WAITE PARK, MN 56387	s,	<u>19291</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F_425	Continued From pa	ge 32	F	425			32 of 4
	During medication of 7:40 p.m., registered up the evening medication of 7:40 p.m., registered up the evening medication and placed medication of the righ and placed the new RN-A, went to their needed to find anoid destruction of the of she requested the additional placed to cut up scissors in her glow been cut up several off her hand (inside glove in the wasteb) During interview baconf her back and placed the factor of	ck to the medication cart on m., RN-A stated that the le destroyed that patch was			 The data collected will presented to the QA Committee by the DNS data collected will be reviewed/discussed at quarterly QA meeting. time the QA Committee make the decision/recommendar regarding any follow-u studies. Date of Completion: February 2013 	5. The the At this e will tion p	2013 2013 2013 2013 2013 2013 2013 2013
FORM CMS-25	need to be witness	cilet. The destruction does ed by another licensed staff the MAR(medication		Fa	acility ID: 00643 f contin	uation shee	Page 33 of 43

DEDAD'		AND HUMAN SERVICES): 01/29/2013
• •		& MEDICAID SERVICES					1 APPROVED). 0938-0391
1	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIP	LE CONSTRUCTION		SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	
		045075	B. WING	G			ം പ്രതിക്കും പ്രതിക്കും
		245375				01/	11/2013 ^{/2013}
	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 2 NORTH FIRST STREET		22-2391
STERLIN	IG PARK HEALTH CA	ARE CENTER			AITE PARK, MN 56387		n san ing sin Ting tang
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2°.					DEFICIENCY)		A State State
F 425	Continued From pa	ana 33	F 4	125			- 33'01'4
109 740	administration reco	-	T 4	20			ر بر میلاد در باری از این از این از این از این از این از این از این از این از این از این از این از این از این ا این از این از ا
		· ~ j.					i din .
		nufacture's instructions, page					att, de av are
		of Fentanyl patches to ving manner: "Used patches					- 2520 - 2524
	should be flushed o	lown the toilet immediately					32 of 42
 	upon removal."						25/2013
itas No.		01/08/13 at 8:14 p.m., the					
		(DON) and the facility					ار بولند می دوند و این با در این اور اور اور اور اور اور اور اور اور اور
* . * *		 both verified and stated that lestroyed according to 					2-1 - 2-1 - 2-2-1
		uction nor facility policy.					2012 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013 - 2013
	No further informat	ion was provided			F428		(1013 and
F 428		EGIMEN REVIEW, REPORT	F 4	28	The preparation of the following	nlan	1.2.2.21
SS=D	IRREGULAR, ACT				of correction for this deficiency of		1.
	The drug regimen (of each resident must be			not constitute and should not be		X6) TETION
Er Kr		nce a month by a licensed			interpreted as an admission nor agreement by the facility of the		15491 172131
19 8 1910 - 1911 - 191	pharmacist.				the facts alleged or conclusions	set	and the state
	The pharmacist mu	ist report any irregularities to			forth in the statement of deficier The plan of correction prepared		1-15-61-65
	the attending physi	cian, and the director of			this deficiency was executed so		
	nursing, and these	reports must be acted upon.			because provisions of state and		
					federal law require it. Without w the foregoing statement, the fac		الم الم الم الم الم الم الم الم الم الم
				ĺ	states with respect to:	ancy	ا بېلې کې د. د مېلې کې د.
10 g					1 Otoff will be advected		1143.01
		NT is not met as evidenced			 Staff will be educated procedure for PRN us 		: 20/2013
	by: Based on interview	v and document review the			and documentation of	Ĩ	2-3-030
		ure the pharmacist identified			effectiveness, by Feb	ruary	بیمونی دینی ود. ایریونی ایری ایک ایریونی ایری
	inadequate monitor	ing of pain medications for 1			18, 2013. 2. Review Pharmacists		
· · ·		3) reviewed for unnecessary ermore, the facility failed to			recommendations and		2007 A. 6826 (1913
1	ensure that pharma	acy recommendations were		ł	facility follow up after monthly visit	each	A CARGE
FORM ON O		Obsolete Event ID: 042V1	1	Facil		uation shee	1
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DEPART	MENT OF HEALTH	AND HUMAN SERVICES							01/29/2013 APPROVED
		& MEDICAID SERVICES							0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			ONSTR	RUCTION	(X3) DATE SU COMPLE	
		245375	B. WI	NG_	·			01/1	1/2013
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F 428	(R57) reviewed for Findings include: R43's received Vice as needed for pain, identify the facility w the medication to d R43's diagnoses in osteoarthritis and o minimum data set (indicated moderate required extensive activities of daily liv R43's physician's o included: Hydrocod 1 tab every 4 hours musculoskeletal pain R43's Medication A 11/26/2012 through received 33 doses The PRN Follow U through 1/6/2013 in 4 out of 33 times bo blank. The progress through 1/8/13, onl PRN Vicodin was eff Review of "Consult	ohysician for 1 of 10 residents unnecessary medications. Defin (a narcotic pain reliever) The pharmacist did not vas not adequately monitoring etermine if it was effective. cluded spondylosis, steoporosis. The quarterly MDS) dated 12/20/2012 cognitive impairment and assistance from staff for ing (ADL's). rders dated 11/26/2012 lone APAP (Vicodin) 5/325 mg, as needed for in. dministration Record dated of 1/8/2013, indicated R43 of PRN (as needed) Vicodin. p Charting, dated 11/26/2012 indicated Vicodin was identified eing effective. The rest were s notes dated 10/23/12 y identified on 12/16/12, the offective, there were no other ed R43 pain and if the	F	428		te of (The DNS or designed complete two audits p week for one month a then one audit per we two months on PRN u The data collected wi presented to the QA (by the DNS. The data will be reviewed/discu the quarterly QA mee this time the QA Com make the decision/recommenda regarding any follow-u Completion: February 1	er ind isage. Il be Committee a collected issed at ting. At mittee will ation up studies.	134 of 45 147 34 of 45 147 34 of 45 147 36 2013 147 26
			1			ገ- በብድቆሳ	3 If possible	nuation shoot	Page 35 of 43
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 042V1	I	ł	Facility II	J. 00040	s ii conti	nuation stiedt	i ago og oj jugo
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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/29/2013 APPROVED 0938-0391
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		245375	B. WI	NG		01/1	1/2013
i i	ROVIDER OR SUPPLIER	RECENTER		1.	EET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		OVED OVED
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΠX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F.428	acknowledge that s effectiveness of as	Iting pharmacist did not taff were not documenting the	F	428			1. 199141 1. 1992(13 1. 1992(13
	consultant pharmac staff need to be foll effectiveness when No further informati R57 received variou antianxiety medicat identified there was physician of why a o clinically contraindio The physician did n R57 had the diagno	cist (Pharm-D), stated that owing up on the results of administering PRN Vicodin. on was provided. us antidepressants, and ions. The pharmacist no clinical indications by the dose reduction attempt is cated for these medications. ot act on these concerns.				•	-720/2018 PROVED 38-0391
	(MDS), dated 11/27 the active diagnose was receiving both anti-anxiety medica orientated. The Psy Assessment (CAA) "Resident has a his depression, he is no depression at this ti depression is well n good. No concerns R57's current physi (anti-anxiety medica a day for anxiety, R	tions, and was alert and chotropic Drug Use Care Area , dated 11/27/12, indicated, tory of and diagnoses of ot displaying signs of me. He states that his nanaged and that he feels					2.2.2.4 2.2.2.4 2.2.2.4 2.2.2.4 2.2.2.4 2.2.2.4 2.2.2.4 2.2.2.4 2.2.4 2.2.4 2.2.4 2.4

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00643

If continuation sheet Page 36 of 43

DEPAR	IMENT OF HEALTH	I AND HUMAN SERVICES					01/29/2013 APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI			(X3) DATE S COMPLE	URVEY
		245375	B. WI			01/1	1/2013
NAME OF P	ROVIDER OR SUPPLIER			ет	REET ADDRESS, CITY, STATE, ZIP CODE		
	IG PARK HEALTH CA	RE CENTER		1	42 NORTH FIRST STREET VAITE PARK, MN 56387		24- <u>839</u> 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	panic attacks and c	nti-anxiety) every bedtime for lonazepam (anti-seizure	F4	128			23.FT
	twice a day as need	nes used for panic) 0.5 mg ded for anxiety. rmacist reviews identified the					andi Sarapeta Salah Salah
DJ M- N-	10/16/12: "when rea facility will need doo reduction attempt is	sident goes to psychiatry, cumentation why dose s clinically contraindicated for decrease, if possible."				• :	29/2013
	11/16/12: "I believe	psychiatry review is pending."					12013 ALLA
	documentation as t contraindicated for this documentation	ecent dictation? Facility needs o why any decrease is psychotropic medications. (if is not in the dictation, then be faxed to request gradual					AND AND AND AND AND AND AND AND AND AND
	dated 11/1/12, the i anxiety was stable, medications and we However, in review progress notes, dat indicated R57 cont which caused anxie was to continue to o	ychiatrist progress notes, notes indicated only that R57's to continue the current ould be seen in three months. of the licensed psychologist ted 11/28/12, the notes inued to have trust issues ety and that the treatment plan explore ways that R57 could					1044 144 144 144 144 144 144 144 144 144
	others. During interview on registered nurse (R	expectations of himself and 01/11/13 at 8:30 a.m., a N-MDS) verified that ongoing king for R57's psychotropic					27132.1 2713
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 042V11		Fa	cility ID: 00643 If contin	uation sheet	Page 37 of 43

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	ultipi Lding		(X3) DATE SI COMPLE	JRVEY TED
		245375	B. Wi	IG		01/1	1/2013
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		OF OFNITED			2 NORTH FIRST STREET		1.14
STERLIN	G PARK HEALTH CA	RECENTER		W/	AITE PARK, MN 56387		e da na de
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F 428	Continued From pa	ge 37	F	428			51-014
2014 12 12	medications, and the notes contradicted	e two mental health providers each other.					
	pharmacist stated t	0 a.m. the consultant hat the psychiatrist did state e, but could see where there					a to a straight
81		when the psychologist					29/2013 > 7VED
E-441	No further informat 483.65 INFECTION	ion was provided. I CONTROL, PREVENT	F	441	F 441		38-0391
SS=F	SPREAD, LINENS				The preparation of the followir	na plan	
.a.t	The facility must es	tablish and maintain an			of correction for this deficiency	y does	· 公省32012
	Infection Control Pi	ogram designed to provide a			not constitute and should not interpreted as an admission n		<u>. 2 22 6 1</u>
₩.,	to belo prevent the	comfortable environment and development and transmission			agreement by the facility of th		N.
-	of disease and infe				the facts alleged or conclusion		
-					forth in the statement of defici		CRAFTERIN RATE
	(a) Infection Contro	I Program			The plan of correction prepare		يحافي مريد .
	Program under whi	stablish an Infection Control			this deficiency was executed a because provisions of state an		ى <mark>يوپېيەرىلارىيە</mark> ئىدى. ئەتتىرىيەرىيەن دەر
7		ntrols, and prevents infections		1	federal law require it. Without		之动有
4.5	in the facility;				the foregoing statement, the fa		The state marks
	(2) Decides what p	rocedures, such as isolation,		į	states with respect to:	*	$\sim \zeta \gamma \xi \alpha$
х }-		o an individual resident; and					
		ord of incidents and corrective			1. The facility has reviewed t		ومراجع ومعروب والم
1	actions related to in			1	infection prevention and trac policy and procedure, and h		ر وه ه اور او محمد محمد او اور محمد او
	(b) Preventing Spre	ad of Infection			designed RN responsible to		ş es
		tion Control Program			maintain the infection preve		2.92613
2	determines that a r	esident needs isolation to			and tracking program		20VEF
		of infection, the facility must			2. Designated RN and nursi		9-0391
1211	isolate the resident	t probibit omployage with a			have been educated on faci		a tana
334	(2) The facility mus	t prohibit employees with a base or infected skin lesions			policies and procedures on provention and tracking prov		
		with residents or their food, if			prevention and tracking prog education will be completed		
		ransmit the disease.			February 18, 2013	~ ;	STVC S
	<u> </u>			1			3-2391

FORM CMS-2587(02-99) Previous Versions Obsolete

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Facility ID: 00643

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING - .i. B. WING 01/11/20132013 245375 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **142 NORTH FIRST STREET** STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 56387 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETIÓN, (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG TAG DEFICIENCY) 38 of 43 F 441 F 441 Continued From page 38 n in in in the second s an States (3) The facility must require staff to wash their Audits will be performed on hands after each direct resident contact for which ्रिष् antibiotic usage and transmission hand washing is indicated by accepted based precautions. These audits 1 compensation professional practice. will be conducted monthly for 3 months. (c) Linens 4. The administrator or designee will Personnel must handle, store, process and 1/29/2013 audit minutes of the committee transport linens so as to prevent the spread of ⊡rs⊙VED P. . meetings to assure the action plans infection. 8-0391 <u>N</u> and facility quality indicators are •• ; being implemented. TELES 12.1 5. The data collected will be brought to the QA Committee The data This REQUIREMENT is not met as evidenced collected will be reviewed/discussed

427013 bv: *....* at the quarterly QA meeting. At this 6.4391 Based on interview and document review the time the QA Committee will make facility failed to develop, implement, and maintain 1 the decision/recommendation έRi-6 C. .-an infection control program to ensure prevention 16 regarding any follow-up studies. and recognition of infections within the facility. (i, i)415. This had the potential to affect all 44 residents HAR CHON. 11 Completion date: February 19, 2013 · payes i . currently residing in the facility. * ****** ما مالیکو کرد. محکوم او دو دو • • • Findings include: 1 C 38 of 45 1 Upon review of the infection control logs since December 2011, the following was noted: The log book contained monthly infection control م. موجود میشوند. data collection for the months of December 2011, 7.42March 2012, June 2012, July 2012, and October 19 2012. The form instructed staff to identify resident name, room number, infection site, organism 22/2015 - POVED ÷ cultured, antibiotic type, stop date, if the infection 14-0391 was present on admission, and any precautions needed. For all five months provided, the ÷ : . 1171 infection control data was not complete nor was 191.00 100 there any analysis of the data to determine any 1320E2 pattern or trends. WELL •••• 5-056H

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 042V11

Facility ID: 00643

If continuation sheet Page 39 of 43



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DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES					APPROVE							
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			A. DOIL	DINC	······································		14. 14.1							
		245375	B. WIN	iG		04/4	1/2013							
						VIII	1/2013							
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(gal)				W	AITE PARK, MN 56387									
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		(X5) · ·							
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					•									
							1							
F,441	Continued From pa	-	F4	41			10.65							
		i 01/10/13 at 3:46 p.m. the		ļ										
		f nursing (ADON), who was		İ			1							
	also the infection c	ontrol nurse, stated the												
20 ¹		ogram was not current. The					43.5							
24		vas currently trying to go back					م بر مرد می اور اور اور اور اور اور اور اور اور اور							
	and update the infe	ection control program but was					// 3d. 0f							
• •	only in the month o	f October, which is the month					· · ·							
	she started with the	e infection control program.		ļ		۰.	01/29/20 PROVE							
	The ADON verified	there was no current infection					03							
	control program in	the facility, which included					12 70 000							
	tracking of resident	or employee infections and	Ĩ				fan fan de serveren serveren serveren serveren serveren serveren serveren serveren serveren serveren serveren En en	also verified it had	not been up to date when she		ļ			in Anna 2
	took over the infect	ion control program.												
		•												
$\frac{1}{2} \in \mathbb{C}^{n}$	Review of the facili	ty policy titled infection Control												
ز سکے	Program dated 1/1	0, indicated "The infection		1										
Ŕ.	Prevention/Control	program exists to assure a					 							
(4) (4)	safe, sanitary and o	comfortable environment for												
ι. L	residents, staff and	visitors. The program goals					::Chộ							
5		evelopment and transmission		-			2415							
		ctionThe early detection,					1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 - 1000 -							
		nagement of infections are					14							
64		igh effective oversight of the												
		n/Control program. Essential												
يەر بە قىر بە		e followingTo provide					- Anna,							
		including planning, organizing,												
		ating, monitoring. To maintain					1,150							
		of the program and ensuring					1 490 1.1. Alto							
÷.		erdisciplinary team is involved					ang Sara Sarahan Sarahan							
		ion and control. To plan												
		nt, operate and maintain all of		1			11/2/20120							
		ntsThe establishment of					NOX4							
		rds and frequency, including		l		•	03							
		utcome surveillance,					a y							
	monitoring of practi	ce, data analysis,					1.1.7.7.7.							
÷.		communicable diseases					1							
		elopment of the education		1			15 2000							
		g the training in infection					1 1 1720							
1							<u>: 07</u>							
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ATEMEN	ENTERS FOR MEDICARE & MEDICAID SERVICES EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
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		245375	B. WING	·····	01/11/2013	
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	compliance. The co including a review of appropriate use of a population to limit th Drug Resistant Org included in the polic Preventionist (IP): includeCollects an trends and provides staff, health care pr Prevention Commit Committee. Consul assessment, preven including transmiss isolation." The polic Surveillance Progra standardized definit symptoms of infecti including infection s templates. Perform identifies the proces surveillance. Compl data that can uncov Communicates the activities to facilitate Implements element Outcome Surveilland data on individual ca	trol practices that ensure onduct of antibiotic review of data to monitor the antibiotics in the resident he development of Multiple anism (MDROs)." Also ey, under Role of the Infection "Responsibilities hd analyzes infection data and b this information to nursing actitioners, the Infection tee and Quality Assurance ts on on infection risk htion, and control strategies ion based precautions and y also included the im Activities, listing "Develops ions and listings of the ons. Uses surveillance tools urveys and data collection s environmental surveys, and opulation at risk for infection. asses or outcomes selected for etes statistical analysis of	F 441		2013 2013 2013 2013 2013 2013 2013 2013	
F 520 SS=C	Program." No further informati 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN	BERS/MEET	F 520			



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		AND HUMAN SERVICES	:		FC	ED: 01/29/2 RM APPROV NO: 0938-03	
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					F 520		
F 520	Continued From pa	ge 41	F 5	520	The preparation of the following plan	्य के दि	
					of correction for this deficiency does	2355. (2355-	
. 1 ¹ 5		tain a quality assessment and			not constitute and should not be	建成种门 1、1月	
		ee consisting of the director of			interpreted as an admission nor an		
		physician designated by the 3 other members of the			agreement by the facility of the truth	of the	
	facility's staff.	5 other members of the			the facts alleged or conclusions set		
				-	forth in the statement of deficiencies.		
ц., .	The quality assessr	nent and assurance			The plan of correction prepared for this deficiency was executed solely		
-1		t least quarterly to identify			because provisions of state and		
		to which quality assessment			federal law require it. Without waivin	•	
		vities are necessary; and			the foregoing statement, the facility	9	
•		ments appropriate plans of entified quality deficiencies.			states with respect to:		
					1.The facility has an active QA	1) 187.00	
1.0		etary may not require			Committee with all required		
121.5		uch disclosure is related to the			membership.		
		committee with the			The QA committee will impleme	nt	
	requirements of this				active quality improvement		
847 4 21	1				programs and will implement and	IS	
		by the committee to identify			develop appropriate plans of action		
		deficiencies will not be used as			for these programs. 3. All staff will be educated	مونونية إيم مورد من الم يقيم مرد مير مدينا مارد مرد مار	
	a basis for sanction	S.			regarding the QA Committee and i	ts a state	
					activities by February 18, 2013.	97 (197 1478 - 1	
		IT is not met as evidenced			4. The administrator or designee w		
• •	by:	The not mot as evidenced			audit minutes of the committee		
* `		and document review the			meetings to assure the action plan	S E	
N	facility failed to prov	ide documentation that the			and facility quality indicators are		
.)) :	quality assurance (0	QA) committee actively met on			being implemented.	r≞ ∦s	
		d failed to ensure physician			 The data collected will be broug to the QA Committee The data 		
an an an an an an an an an an an an an a		e quarterly meetings. This had			collected will be reviewed/discusse	ed :: 03	
	currently residing in	ct all 44 residents that are			at the quarterly QA meeting. At th		
	currently residing in				time the QA Committee will make	- T.	
	Findings include:			1	the decision/recommendation		
					regarding any follow-up studies.	11277	
	Review of the facilit	y QA attendance logs			Completion date: February 19, 2013		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		TH AND HUMAN SERVICES				PRINTED: 01/29/201 FORM APPROVE OMB NO: 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
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F.520	indicated that the meet quarterly. The which included 04 of attendees but in was present at the During an intervier 01/11/13 at 10:55 conduct an Octobe not provide any me attendees. She fur director was not a stated she could in present at the 04/ meetings as she he this facility only sin	facility QA committee did not ne log identified meeting dates /17/12 and 07/17/12, and a list to indication that a physician e meetings. w with the administrator on a.m., she indicated they did er, 2012 QA meeting but could eeting minutes nor the list of rther stated that the medical t the October meeting. She not verify if a physician was 17/12 and 07/17/12 QA has been the administrator at nec September 20, 2012, further an issue, it is my goal to get a	F 52	20		42 of 41 E 10 41 E 10 7 25/201 9 KOME 31-03E 19 5/201 19
					·	- 4220 - 110VE - 110VE
RM GMS-256	37(02-99) Previous Version	s Obsolete Event ID: 042V11	F	acility ID: 00643	If continuati	on sheet Page 43 of 4
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SENIOR COMMUNITY Addendum to Sterling Park Health Care Center Plan of Correction Part II

Replace ED with Administrator in all instances

F166

Change current #2 to:

2. Resident #6 requested a private room, facility did not have a private room to offer Resident #6 and was then offered a semi private room for herself and was told she would not get a roommate however both beds would remain in the room, which was identified on resident care plan as of 11/7/13. This will be reviewed ongoing with resident and again with resident/family at care conference on 1/21/14. As the family now shows disagreement with this arrangement and the facility currently does not have any long term private rooms available, as of 1/24/14 the resident will no longer be charged for the private room. Facility has offered to assist resident in finding alternative placement at a facility with a long term private room available and resident has declined the offer at this time.

F225 and F226

Add 1-4 Change current #3 to #5:

1. With new information provided to facility regarding R6 allegation, it was reported to the State Agency. NA was placed on suspension immediately, investigation was performed resulting in NA termination.

2. Facility reassessed R32, R48, and R11 for falls and care plan was updated accordingly.

Resident incidents and suspected abuse will be reported to DNS/Administrator immediately
 All incident reports will be scanned and emailed to DNS/Administrator and/or designee immediately for review when unavailable in the building

5. DNS/Administrator or designee will determine if incident/allegation is reportable to state agency, repor to State Agency immediately if determined necessary, and begin investigation. All abuse allegations are to be reported to the State Agency immediately.

F244

Change current #2, Add #4

1. Facility protocol for resident council was updated to include a standard agenda, minutes and follow up documentation.

2. An IDT member will seek invitation to resident council meeting monthly

3. IDT member that attended meeting with review minutes for accuracy, monthly. All concerns will be review by IDT and addressed with appropriate department.

4. Individual concerns will be followed up on individually in accordance with our Quality Improvement Process. Group concerns will be followed up on at next months meeting as Old Business. If resolution has not been reached it will be re-addressed

Health Care Center
(Skilled Care)
142 N. 1st Street
Waite Park, MN 56387
320-252-9595
Fax: 320-252-9216

Commons (Assisted Living) 35 Ist Avenue N. Waite Park, MN 56387 320-252-7224 Fax: 320-252-5629

Park Gardens (Independent Living) 114 N. 1st Street Waite Park, MN 56387 320-252-7224 Fax: 320-252-5629

F248

Change current #2 and #3 to:

2. All residents determined to be dependent on staff will have there activity preferences re-evaluated by 1/24/2014. All residents activity preferences are assessed on admission, annually and with significant change in condition and reviewed on a quarterly basis.

3. The DNS/Administrator and/or designee will perform audits to ensure the activity care plan is being followed, and resident attendance is being tracked, complete two audits per week for one month then weekly for two months.

F282

Change current #8

 8. The DNS/Administrator and/or designee will perform audits daily to ensure the care plan is being followed with all fall incident reports, to include fall prevention interventions.
 9. The DNS/Administrator and/or designee will perform five audits a week for one month to ensure residents dependant on staff are being repositioned according to the care plan

F309

Add #3:

3. Facility IDT reviews residents for changes in condition including weight gain or loss, and falls five days a week. The facility IDT team will discuss all residents identified to be at risk for weight loss or gain five days a week. Falls are reviewed at daily IDT for appropriate incident reporting, follow up and root cause analysis to determine appropriate preventative interventions.

F314

Change current #4 to:

4. The DNS and/or designee will perform audits to ensure those residents dependent on staff for repositioning are being repositioned according to the care plan. Two audits will be completed weekly for one month, then one audit weekly for two months.

F323

Corrected pages 71-79 sent with initial Addendum. These pages were not correct on the original copy of the POC, however were correct in the attachment to the addendum. Change current #4 and #5:

2. All incidents are reviewed by DNS/Administrator or designee daily for appropriate interventions, to assure that care planned approaches were being followed, and to review for possible vulnerable adult reporting.

4. R11 had new fall assessment completed, care plan reviewed, and interventions updated for falls.

5. R66 R11 had new fall assessment completed, care plan reviewed, and interventions updated for falls. R66 has since discharged home.

F353

Change original #2 to #4:

2. Staffing analysis has been completed to identify specific times of increased call light usage, increased resident needs, has been completed to identify specific times when additional monitoring and/or assistance may be required. Staffing schedules continue to be adjusted accodingly. Open positions have been filled and staff have begun working. Pool agency staff were utilitized to supplement during transition.

3. Residents/Families will be interviewed prior to or during care conferences and at random to monitor effectiveness of staffing adjustments.

4. Audits will be conducted with each call light review to assure that sufficient staffing present in building and to review for patterns. This audit will include resident and staff interviews.

F356

Correction

Completion date: January 24, 2014

F441

Corrected pages 117-118 attached.

Heather Potter 1/24/2014

FPART	MENT OF HEALTH	AND HUMAN SERVICES			RECEIVED	FORM /	01/10/2014 APPROVED
ÉNTER	S FOR MEDICARE	& MEDICAID SERVICES			0	1	0938-0391
TEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION JAN 2 1 2014	(X3) DATE COM	SURVEY
	•	245375	B. WING	20/2013			
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		DE CENTER			2 NORTH FIRST STREET		
TERLIN	G PARK HEALTH CA			VV.	AITE PARK, MN 56387		
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F 000	INITIAL COMMEN	rs	F	000			
	conducted by the M Health on December 2013. The survey Jeonardy (JJ) at F3	tification survey was Iinnesota Department of er 16, 17, 18, 19, and 20th, resulted in an Immediate 23 related to the facility's sident falls were thoroughly					
	failure to ensure resident falls were thoroughly assessed to prevent further injury which resulted in actual harm. The facility staff had been notified of the IJ on December 19th, 2013, at 6:00 p.m. The IJ was removed on December 20th, 2013, at 2:00 p.m., however non-compliance remained at the lower s/s of a G, isolated actual harm.				•	· · · · ·	
	as your allegation Department's acce bottom of the first r	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.					
F 157 SS=D	revisit of your facili validate that substr regulations has be your verification. 483.10(b)(11) NOT	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with TIFY OF CHANGES E/ROOM, ETC)	F	َ 157	F 157 The preparation of the following p correction for this deficiency does constitute and should not be inter as an admission nor an agreeme the facility of the truth of the facts	s not rpreted nt by	•
	consult with the re known, notify the r or an interested fa accident involving injury and has the intervention; a sign physical, mental, o deterioration in he status in either life	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in potential for requiring physician hificant change in the resident's or psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or	i ali	14 order	alleged or conclusions set forth ir statement of deficiencies. The pl correction prepared for this defici was executed solely because pro of state and federal law require it. Without waiving the foregoing statement, the facility states with to:	an of ency wisions	
BORATOR	LY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	IL H VI		F	101	utile Director	·/ •	17.14
v deficier	cv statement ending with	n an asterisk (*) denotes a deficiency w	hich the i	institu	tion may be excused from correcting providing	ng it is dete	ermined that

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245375	B. WING			12/	20/2013
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STERLIN	IG PARK HEALTH CA	RE CENTER		-	12 NORTH FIRST STREET /AITE PARK, MN 56387		
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F 157	significantly (i.e., a existing form of treat consequences, or to treatment); or a dec the resident from th §483.12(a). The facility must als and, if known, the re- or interested family change in room or re- specified in §483.1 resident rights under regulations as spect this section. The facility must reac- the address and ph legal representative This REQUIREMEN- by: R50 had symptoms edema. The facility about these sympto- R50's admission MI she had mild cognition unknown weight loss on a diuretic (medic R50's hospital Histor 11/7/13, indicated diatrial fibrillation, and failure (CHF). The F R50 was hospitalized	 hs); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge is facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or iffied in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. NT is not met as evidenced as of weight gain, dyspnea and did not notify the physician or so r weight gain, and was not action to reduce fluid). DS dated 11/22/13, indicated is or weight gain, and was not action to reduce fluid). ory and Physical dated iagnoses of hypertension, a resolving congestive heart distory and Physical revealed as secondary to recurrent falls, 	F	157	 monitored daily per physician order Weight has been stable greater that days. RD does have resident on his risk list and will continue to follow resident's weight changes. Ongoing communication with MD will be completed if change noted per char in condition guidelines. Resident #48 had blood pressure monitoring every 2 hours from 12/2 through 12/26/13 with no significant elevated blood pressures noted. Progress noted will be reviewed DNS or designee 5 times per week weeks. Nursing staff-education will be completed by January 24, 2014 on policy and procedure for change in condition and notification of physici 4. The DNS and/or her designee w conduct audits weekly on any resid with a change in condition. All incident reports will be reviewed by DNS, ED and/or designee post incident for discrepancies in vital si and injury. The data collected will be reviewed/discussed at the monthly meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies and required 	s. n 30 gh nge 0/13 t by for 4 an. III ents red gns QA	
)RM CMS-25	R50 was hospitalize	ed secondary to recurrent falls, is and confusion. It also		Faci			Page 2 of 120

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		AND HUMAN SERVICES					APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
STERLING PARK HEALTH CARE CENTER					142 NORTH FIRST STREET WAITE PARK, MN 56387			
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F 157	admission to the ho 11/10/13. R50's ho 11/11/13, indicated milligrams (mg) and discharge orders in if you gain 3 [three] gain 5 [five] pounds directed a referral of appointment with ho R50's current care a problem of hypert anti-hypertensive m medications). The her medical practitio of malignant hypert headache, visual po difficulty breathing. R50 had a history of to monitor for fluid m Review of the facilit Summary revealed 11/12/13 118 lbs (u) hospital discharge 11/16/13 119 lbs 11/19/13 119 lbs 0n 11/20/13, R50's physician visit from 11/20/13, nine days 11/20/13, nine days 11/20/13 office visit was 117 lbs. The p up ten lbs and had and lower extremity ordered hydrochlore	t was 105 pounds (lbs) on ospital and 108 lbs on spital discharge orders dated she received atenolol 50 d diovan for hypertension. The structed to "call your physician pounds or more over night, or a in a week" The orders also on 11/20/13, for a follow-up er physician. plan dated 11/27/13, identified tension and received nedications (blood pressure plan instructed staff to notify oner of any signs or symptoms ension including the following: roblems, confusion, and The care plan did not indicate of congestive heart failure and retention and weight gain. ties Weights and Vitals the following weights: p ten lbs (pounds) from weight on 11/11/13) had a scheduled follow up her hospital discharge. The noted indicated R50's weight hysician commented R50 was dyspnea (difficulty breathing) redema. The physician othiazide 25 mg daily (used to	F	157				

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Facility ID: 00643

If continuation sheet Page 3 of 120

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	should have had co symptoms for conge placed on an edema She stated the phys aware of the resider The ADON verified and should have. Even though R50 ha lower extremity ede the facility failed not change in her condi An undated Change to the MD/NP/PA for directed weight gain symptoms, or weigh or five lbs in one we medical practitioner. Based on interview a facility failed to ensu multiple falls with he pressures, which red for 1 of 5 residents (facility also failed a p symptoms of conges residents (R50) revise Findings include: R48 had elevated ble injuries, and abnorm	nursing (ADON) stated R50 ntinued monitoring of estive heart failure and been a measurement flow sheet. ician should have been made nts weight gain on 11/12/13. this had not occurred for R50 ad symptoms of dyspnea and ma with a ten Ibs weight gain, ify R50's practitioner of this tion. in Condition, When to Report m provided by the facility, associated with respiratory t gain of three Ibs in one day ek were to be reported to the and document review, the re a physician was notified of ad injury, and elevated blood quired physician intervention R48) reviewed for falls. The ohysician was notified of stive heart failure, for 1 of 4 ewed for nutrition.	F	157				
		n of them.		Facili	ity ID: 00643	If continuation	n sheet l	Page 4 of 120

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			*	Ö		0938-0391
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F 157	10/18/13, included hypertension (eleva dementia. The MD cognitive impairme	inimum Data Set (MDS) dated diagnoses of hip fracture, ated blood pressure), and DS indicated R48 had severe nt, required extensive ctivities of daily living (ADL's),	F 1	57	لہ			
	hypertension (high and directed staff to to medical practitio [signs or symptoms Headache, visual p disorientation, letha	ted 10/24/13, included blood pressure) as a focus, o, "Observe/document/report ner PRN [as needed] and s/sx s] of malignant hypertension: problems, confusion, argy, nausea and vomiting, activity, difficulty breathing			• • •			
	three medications	ders dated 12/2/13, included to control hypertension: iligrams) daily; Cozaar 60 mg L 100 mg daily.				· .		
·	indicated she had f Blood pressures at documented as: ly hg (mercury) and pressure 120/80). pressure (183/76) record under Progr 5:07 a.m. R48's bl elevated more than was no evidence ir indicate her physic	tident Report dated 10/27/13, fallen in her room at 11:25 a.m. t the time of the fall were ving 203/82 mm (millimeters) sitting 167/76 (normal blood The next documented blood was located in R48's electronic ress Notes dated 10/28/13, at lood pressure remained in 17 hours after the fall. There in R48's medical record to bian had been notified of the ssures or of the drop in blood lying and sitting.						
		ident Report dated 11/2/13, at	<u> </u>					
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DEPART		AND HUMAN SERVICES & MEDICAID SERVICES			C		APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPL	E CONSTRUCTION		E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
					42 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	RECENTER		Ý	VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	with a blood pressu of the fall. R48 hit Neurological Assess initiated, which inclu- checks during the 2 addition, the Neuro Sheet indicated R4 pain on 11/2/13, at a.m. The final blood at 12:30 a.m. was blood pressure (18 Signs in the electro 10:29 a.m. R48's the elevated three days evidence in R48's r physician had been pressure or of the fine head. R48's Resident Inc 12:30 a.m. indicate During this fall, R48 three centimeter (c (large collection of back of her head. time was 181/84 si Neurological Assess	d a second fall had occurred, ire of 215/81 noted at the time her head during the fall and a sment Flow Sheet was uded frequent blood pressure 24 hours following the fall. In logical Assessment Flow 8 had complained of head 12:05 a.m., and again at 3:50 d pressure check on 11/3/13, 176/70. The next documented 7/78) was located under Vital onic record dated 11/5/13, at blood pressure had remained a fater the fall. There was no medical record that the notified of her elevated blood nead pain after hitting her ident Report dated 11/8/13, at d R48 had fallen a third time. 8 hit her head and sustained a m) by four cm hematoma blood under the skin) to the R48's blood pressure at that tting and 199/103 lying. A sement Flow Sheet was	F	157			
	initiated, dated 11/8 checks were comp hours. At 4:00 a.m elevated at 199/75 Assessment Flow 5 had been equal rou 8:00 a.m. at which sluggish (a potentia remained sluggish when the assessm	8/13, and blood pressure leted every four hours for 24 . her blood pressure remained					
ORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 6U131	1	Fa	cility ID: 00643 If continua	uon sneet	Page 6 of 120

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		AND HUMAN SERVICES				FORM	: 01/10/2014 APPROVED . 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	PLE CONSTRUCTIO G			TE SURVEY MPLETED
		245375	B. WING			12	/20/2013
NAME OF I	PROVIDER OR SUPPLIER				, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER		142 NORTH FIRS			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORREC ORRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	DULD BE	. (X5) COMPLETION DATE
F 157	Continued From pa a.m.	ge 6	F 15	7			
	noted R48 complain vomited after break contacted and, "Ex- know if she has any with a CT scan. Fa aggressive in reside [family member] red At 2:05 p.m., anoth R48's, "Pupils are so nurse had noted thi indication in R48's of physician had been	ted 11/8/13, at 11:10 a.m. ned of a headache and had fast. R48's relative was plained that the only way to y bleeding present would be amily does not want to be ents care and at this time quests that we just monitor" er progress note indicated sluggish with reaction, but is prior to fall." There was no medical record to indicate her a contacted about the elevated upils becoming sluggish, or the					
	1:30 a.m. indicated again hitting her he the time of the fall v sitting. A Neurologi had been initiated fa fall, with blood press 114/55-168/89. R4 sluggish throughour evidence in the mer had been notified of pressures, or the sl R48's medication a starting 11/20/13, in	uggish pupils. dministration record (MAR) cluded, "B/P and P [blood					
	update [nurse pract needed]." The bloc between 113/61 to evidence the NP or] qd [every day] x 1 week, itioner (NP)] PRN [as od pressures recorded were 183/96. There was no physician had been notified of pd pressures at the time of her Obsolete Event ID:6U131		acility ID: 00643	If contin	nuation sheet	Page 7 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		.245375	B. WING			12/	20/2013
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG PARK HEALTH CA				42 NORTH FIRST STREET		
SIERLIN	·			V	NAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	R48's NP Nursing H 11/22/13, included a noted, "I do not hav review, but I am not problems." The NF Assessment, "Hype of any problems." R48's Resident Inci 10:25 p.m. indicate The report noted Re the fall. R48's bloo recorded as 210/83 Assessment Flow S pressures recorded over the 24 hours for were recorded as e A Centracare Clinic	1/2/13, 11/8/13, or 11/13/13. Home Rounds report dated a physical exam. The NP re weights or vital signs to t made aware of any	F	157			
	pressure reading of evidence the physic 210/83 and 200/83 or sluggish pupils. R48's Nursing Hom dated 12/11/13, incl November 8, 2013, complication]; also physical exam the r reasons, her blood available." There w was informed of the 11/8/13, 11/13/13 a symptoms of vomiti neurological assess indication the physic	f 161/66. There was no cian had been notified of the readings, or the non-reactive le Rounds by the physician luded, "She had a minor fall on without sequelae [without on October 28, 2013. Under note included, "For technical pressures and weights are not vas no evidence the physician a head injury sustained on and 11/24/13 with the ng, head pain, and abnormal sments. Also, there was no cian was informed of the ssures following each falls			cility ID: 00643		Page 8 of 120

CENTER	RS FOR MEDICARE	& MEDICAID	SERVICES				0	MB NO.	0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/S		1		LE CONSTRUCTION			E SURVEY IPLETED
		24	5375	B. WING				12/	20/2013
	PROVIDER OR SUPPLIER	RE CENTER			1	STREET ADDRESS, CITY, STATE, 2 42 NORTH FIRST STREET WAITE PARK, MN 56387	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC` REGULATORY OR L	TEMENT OF DEFIC Y MUST BE PRECE SC IDENTIFYING II	DED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD	BE.	(X5) COMPLETION DATE
F 157	Continued From pay which occurred on and 11/24/13. When interviewed of director of nursing of nursing to recheck half hour after her f notify the physician remained elevated. noted from her seco have reported these R48 had a third fall nursing should have about the change ir vomiting, and her fa fourth and fifth falls and 11/24/13), the f have notified R48's concerns over high reaction after the he that she expected r blood pressures fro verified the physicia falls occurred. The should also have m aware of any eleval their nursing home 12/11/13, respective	10/27, 11/2, 11 on 12/19/13, at (DON) stated s R48's blood pr irst fall on 10/2 if her blood pr R48's reported on fall on 11/2 e symptoms to on 11/8/13, the e notified R48's n her pupil read which occurre DON stated nu physician imm blood pressure ead injury. The nursing to report m all falls to the an was not noti DON confirmed ade R48's NP red blood press visits on 11/22	2:50 p.m. the essure within a 7/13, and to essure ad head pain 2/13, and should the physician. DON stated s physician otion, headache, tions. R48, d on (11/13/13, rsing should nediately with es and her pupil DON added rt elevated e physician and fied when these d that nursing and physician sures during		157				
	An undated facility p When to Report to to /NP/PA (physician's report any systolic (pressures over 210 over 115 immediate 90 the next day. Th need to contact the sustained a contusi fall with no other co	the MD (medic assistant) dire heart contracti , diastolic (hea ly, and diastoli he form also ind physician if the on associated mplications, ar	al doctor) cted staff to on) blood rt relaxation) c routinely over dicated the e resident with a recent nd to send the						
RM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6U1311		Fac	ijlity ID: 00643	If continuatio	n sheet F	Page 9 of 120

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245375	B. WING	:	12/20/2013
AME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
TERLIN	IG PARK HEALTH CA	RECENTER		142 NORTH FIRST STREET NAITE PARK, MN 56387	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 157	Continued From no	ao 0	F 157		
F 107	resident to the eme	rgency room immediately		F 164	
F 164 SS=D	PRIVACY/CONFID	(4) PERSONAL ENTIALITY OF RECORDS e right to personal privacy and	F 164	of correction for this deficiency do not constitute and should not be interpreted as an admission nor a	an
	confidentiality of his records.	or her personal and clinical cludes accommodations,	• •	agreement by the facility of the tr the facts alleged or conclusions s forth in the statement of deficience The plan of correction prepared f	set cies.
-	medical treatment, communications, pe meetings of family a	written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private		this deficiency was executed sole because provisions of state and federal law require it. Without wa the foregoing statement, the facil states with respect to: 1. Resident #47is being t	aiving ity rialed
	section, the residen release of personal individual outside the			with wearing shorts an resident is not in agreement, facility will continue to trial differe options for privacy, wh	nt ile
	and clinical records resident is transferr institution; or record	to refuse release of personal does not apply when the ed to another health care release is required by law.		honoring resident right choice. 2. Care sheets have been updated to reflect resid #47 dressing preference	n Jent ces
	contained in the res the form or storage release is required l	ep confidential all information ident's records, regardless of methods, except when by transfer to another n; law, third party payment		3. Nursing staff education be completed by Janu 24, 2014, to include re bill of rights regarding privacy, dignity and re	ary sident
	contract; or the resid	dent.		4. The DNS and/or her designee will conduct	two
	by: Based on observat	IT is not met as evidenced ion, interview and document ailed to implement measures		audits weekly for one and then once weekly two months for dignity resident choice.	for

ORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00643

If continuation sheet Page 10 of 120

DEPARI	MENT OF HEALTH	AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245375	B. WING		:	12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RE CENTER		W	AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	to ensure personal (R47) reviewed for Findings include: R47's admission M 7/17/13, included a The MDS identified impairment, require catheter, a gastric received total assis needs. On 12/17/13, durin between 10:27 a.m observed in his res The door was note bed positioned by t partially open. R47 was positioned with supported by a pillo covered by a blank was uncovered, ex as well as his cathen nursing assistant (I nurse were observ door. None of the was provided with On 12/18/13, at 6.4 from the sidewalk of window of his resid a T-shirt, with a bla and feet. R47's mi exposing his incon On 12/18/13, at 6.5 from the hallway, w his incontinent brie for the window nex	privacy for 1 of 1 resident personal privacy. inimum Data Set (MDS) dated diagnosis of quadriplegia. R47 had no cognitive ed an in indwelling supra-pubic (PEG) feeding tube, and stance from staff for all daily g continuous observation , and 12:06 p.m., R47 was ident room, lying on the bed. d as wide- open, with R47's he window and the blinds was dressed in a T-shirt and n his knees slightly bent, bw. R47's feet and knees were ret; however, his mid-section posing R47's incontinent brief, eter tubing. During this time, a NA), maintenance person, and ed to walk past R47's open staff intervened to ensure R47 personal privacy. 0 a.m. R47 was observed butside the facility, through the lent room. R47 was dressed in inket covering his lower legs d-section was left uncovered, tinent brief. 50 a.m. R47 was observed with the door wide-open, and f exposed. The window blinds t to R47's bed were completely		164	 The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the monthly QA meeting. At this time the QA Commendation regarding any follow-up studies. Completion date: January 24, 201 	be he ittee on 14	
RM CMS-2	567(02-99) Previous Version	S Obsolete Event ID: 6U131	1	Fac	cility ID: 00643 If continuation	on sheet P	age 11 of 120

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EPART	MENT OF HEALTH	AND HUMAN SERVICES			0	MB NO.	0938-0391
	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245375	B. WING			12/2	0/2013
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387		
TERLIN			ID	V	BROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION
(X4) ID PREFIX TAG	(CACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
F 164	were observed driv observation, nume personnel, and a v R47's open door. ensure R47 was p On 12/18/13, at 9: observed to be wid brief exposed to a Review of R47's c 10/16/13, address his ability to make noted, "[R47] Doe other residents se covers, leaving br exposed, he was The care plan did curtain to maintain During an intervie NA-B stated, "We close the privacy bed and have the was not exposed. difficult to work wi door closed. NA" that he could b further added R4 was on the groun could be seen fro "No resident, staf able to walk by a including R47, un brief exposed. In an interview or	v faced a busy street and cars ving by. During this rous NAs, physical therapy visitor were noted to pass by None of the staff intervened to rovided with personal privacy. 44 a.m. R47's door was again de-open, with his incontinent nyone who passed by his room. are plan, last updated on ed R47's intact cognition and decisions. The care plan s not care if visitors, staff, or ee him lying in bed without ief and legs and catheter bag more comfortable uncovered." not direct staff to pull a privacy n personal privacy for R47. w on 12/19/13, at 8:20 a.m. try to keep [R47] covered," curtain in his room round his drapes partially drawn so he NA-B explained R47 could be ith and did not want his room B added, "[R47] does not care pe seen from the hallway. NA-B 7 was often reminded the room d floor with a window and he m the outside. NA-B stated, f, or visitors," should have been room, and see someone, aclothed, with his incontinent	3	164			
	licensed practica	I nurse (LPN)-A stated when			lffinu	tion choot	Page 12 of 12

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If continuation sheet Page 12

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FORM APPROVED

DEPART		AND HUMAN SERVICES			C		APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DAT	E SURVEY PLETED
		245375	B. WING	i		12/2	20/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RECENTER			VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 164	closed, but R47 oft closed, even when LPN-A stated, "I pe see residents expo view. She added, ' During interview on director of nursing of the privacy issue acknowledged R47 and he was visible undraped window t door or window. TI concern for R47 was his incontinent brie the room, made no personal privacy. A the facility provided implemented to ens 483.10(f)(2) RIGHT RESOLVE GRIEVA A resident has the facility to resolve gr have, including tho of other residents. This REQUIREMED by: Based on observa review, the facility for	47 they kept the room door en refused to keep the door wearing next to nothing. rsonally would not like" to sed or receiving cares in open That's not right." 12/19/13, at 10:20 a.m. (DON) stated she was aware with R47. DON 's door was often wide open from the hallway or an o anyone who passed by his ne DON stated the privacy as well documented and added shes had to be respected. observed multiple times with f exposed with staff walking by attempts to ensure R47's lso, there was no indication I other measures that could be sure R47's personal privacy. TO PROMPT EFFORTS TO		164	F 166 The preparation of the followin of correction for this deficiency not constitute and should not be interpreted as an admission not agreement by the facility of the of the facts alleged or conclusi set forth in the statement of deficiencies. The plan of correc prepared for this deficiency wat executed solely because provition of state and federal law required Without waiving the foregoing	does of an truth ons ection sions e it.	
	residents (R51 and	R6) who had expressed			statement, the facility states w respect to:		
RM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: 6U1311	l	Fa	cility ID: 00643 If continuation	on sheet Pa	age 13 of 120

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		245375	B. WING				/20/2013
	PROVIDER OR SUPPLIER		1	14	TREET ADDRESS, CITY, STATE, ZIP COU 12 NORTH FIRST STREET VAITE PARK, MN 56387	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAĠ		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 166	private resident roo bed for the facility. Findings include: R51's complaints o times were not effe facility. R51's annual Minim 10/8/13, included a (paralysis of all limit intact, showed verb required extensive activities of daily liv incontinent of bowe When interviewed of R51 stated she offe periods of time, sor she needed assista she was paralyzed herself. She added rushed, they say the me feel bad for nee stated she had repor nurses and the dire however, she repor they are not working never changes." During a follow-up i a.m. R51 stated she so long for someone indicated she some hour for response to	call light wait times and om space being used to store a f untimely call light response ctively addressed by the num Data Set (MDS) dated diagnosis of quadriplegia os). R51 was cognitively val behaviors towards others, to total staff assistance for all ing (ADLs), and was always	F	166	 Resident #51 has be interviewed by DNS states that call light response time has "g much better since th was here". Resident #6 request private room, facility have a private room resident #6 and was offered a semiprivate for herself and was t would not get a room however both beds w remain in the room, w was identified on res care plan as of 11/7/ this will be reviewed ongoing with residen again with resident/fa care conference on Facility will continue resident alternative ro as the become availa All resident/family grievances/concerns followed up on per fa quality improvement Education to staff reg resident grievances a policy will be complet January 24, 2014 The DNS and/or her designee will comple audits per week for o month then weekly for months regarding res grievances/concerns The data collected wi presented to the QA 	and gotten e state ed a did not to offer then e room old she mate vould which ident 13 and t and amily at 1/21/14. to offer coms able. will be cility policy garding and ted by te two ne or two sident	

		AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING			12/	20/2013
	PROVIDER OR SUPPLIER	RE CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 2 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	aides say they are through helping me I have to wait to ge pad changed." R5 why a baby cries w stated she began to wait a long time. S result in a response told she had to be p working short. R51's call light logs 12/18/13, revealed activated for over 2 All of these times w 12:15 a.m. On 12/0 wait was 61.2 minu her call light wait tin R51's care plan dat at high risk for deve to urinary incontine staff for cares. The behavior problems assistance after sh care plan directed s as appropriate." When interviewed of DON explained the "Monitor call light til that if R51 complain logs for long wait til see why the waits of confirmed she was concerns of long ca DON had not check The DON had not in	ge 14 short staffed, and they rush . I feel bad they are short, but t a drink of water, or get my 1 then stated, "Now I know hen their diaper is wet" R51 o "holler" out when she had to he indicated hollering did e from staff, but she was then batient because they were from 11/18/13, through her call light had been 5 minutes on 18 occasions. were between 5:55 p.m. and 5/13, at 7:11 p.m. her call light tes. On 12/8/13, at 7:02 p.m. ne was 58.5 minutes. ted 10/9/13, indicated she was eloping pressure ulcers related nce and dependence upon e care plan also indicated related to calling out for e activated her call light. The staff to, "Monitor call light times on 12/19/13, at 8:30 a.m. the care plan instruction of, mes as appropriate," meant hed, she reviewed the call light mes and checked with staff to vere so long. Though she aware R51 had expressed all light response times, the ked the call light logs recently. mplemented any actions in g call light waits for R51.	F		Committee by the DNS The data collected will reviewed/discussed at monthly QA meeting. this time the QA Comr will make the decision/recommenda regarding any follow-u studies. Completion date: January 24, 20	be the At nittee tion p	

RM CMS-2567(02-99) Previous Versions Obsolete

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	•	AND HUMAN SERVICES					FORM	: 01/10/2014 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION			E SURVEY IPLETED
		245375	B. WING	;			12/	20/2013
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			A NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPF	BE	(X5) [`] COMPLETION DATE
	R6 was in a private requested an extra room. The facility d stated the bed need R6's quarterly MDS cognition was intact staff assistance for On 12/16/13, at 4:20 observed to have tw positioned against th bed was stacked wi and miscellaneous i During interview on stated she was happ the facility; however asked the facility set other single bed out space to put her bell told they (the facility) to store the bed, but another place to put located. R6 stated s months ago to have she continued to reo the facility regarding remove the bed. R6's Progress Note "Social services met pleasant and stated She continued to sta room with only one b offer alternative roon appropriate"	resident room and had bed be removed from her lid not remove the bed and led to be "stored" in her room. dated 10/15/13, identified her and she required extensive all ADLs. 0 p.m. R6's room was /o-single beds. One bed was he wall by her window. The th a pile of papers, clothes, tems. 12/16/13, at 4:30 p.m. R6 by she had a private room at , she revealed that she had veral times to remove the of her room so she had more ongings. R6 stated she was) did not have another place it would be removed once the extra bed could be she had asked several the extra bed removed and ever the same response from their lack of storage space to dated 11/21/13, indicated, with [R6] today. She was satisfaction with her room te a desire to have a private bed as available. Staff will	F	166				
DRM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: 6U1311		Faci	lity ID: 00643	If continuation	sheet Pa	 ge 16 of 120

				PRINTED: 01/10/2014 FORM APPROVED OMB NO. 0938-0391
FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
	245375	B. WING		12/20/2013
ER OR SUPPLIER				
RK HEALTH CA	RECENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387	
EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	IX (EACH CORRECTIVE ACTION SHOUL	D BE COMPLÉTION
d R6 had społ requesting th be removed. anywhere to s ust been keep verified the fa s which were ents but stated rooms availa verified no re- ding removing of interview or er (SW)-A sta pare bed removing y was short or it in R6's room en to R6 and he quests to hav ility policy on r requested but (3(c)(1)(ii)-(iii), STIGATE/REI GATIONS/INI acility must no found guilty o eating residen a finding entered try concerning sidents or misa eport any know of law against ate unfitness fo facility staff to	ten to her, "A couple months e spare bed in her private DON stated the facility did not store the spare bed so they ing it in the resident's room. cility currently had empty not being used by any d the facility needed to keep ble for any new admissions. solution was really made the extra bed. 12/17/13, at 12:15 p.m. Social ted she was aware R6 wanted oved from her room, but the n storage space and needed to n. SW-A stated she had her family members regarding the extra bed removed. (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry		F 225 F 225 The preparation of the following of correction for this deficiency not constitute and should not be interpreted as an admission nor agreement by the facility of the of the facts alleged or conclusio set forth in the statement of deficiencies. The plan of correc prepared for this deficiency was executed solely because provis of state and federal law require Without waiving the foregoing statement, the facility states wit	does e r an truth ons ction s ions it.
	DR MEDICARE FICIENCIES RECTION ER OR SUPPLIER RK HEALTH CA SUMMARY STA EACH DEFICIENCY EQULATORY OR L SUMMARY STA EQULATORY SUMMARY STA EQULATORY SUMMARY STA EQULATORY SUMMARY SUM	RECTION IDENTIFICATION NUMBER:	DR MEDICARE & MEDICAID SERVICES FIGIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILE RECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILE 245375 B. WING ER OR SUPPLIER 245375 B. WING CALL SUMMARY STATEMENT OF DEFICIENCIES ID PREFI SUMMARY STATEMENT OF DEFICIENCIES ID PREFI EACH DEFICIENCY MUST BE PRECEDED BY FULL (EQULATORY OR LSC IDENTIFYING INFORMATION) F inued From page 16 id R6 had spoken to her, "A couple months " requesting the spare bed in her private in be removed. DON stated the facility did not e anywhere to store the spare bed so they lust been keeping it in the resident's room. I verified no resolution was really made rding removing the extra bed. IN erified no resolution was really made rding removing the extra bed. Ing interview on 12/17/13, at 12:15 p.m. Social (er (SW)-A stated she was aware R6 wanted pare bed removed from her room, but the ty was short on storage space and needed to e it in R6's room. SW-A stated she had en to R6 and her family members regarding equests to have the extra bed removed. sility policy on resolving resident grievances requested but not provided. F 2 acality must not employ individuals who have a finding entered into the State nurse aide try concerning abuse, neglect, mistreatment sidents or misappropriation of their property; report any knowledge it has of actions by a cof law against an employ	T OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES (C) MULTIPLE CONSTRUCTION RECTION (C) PROVIDENSUPPLENCULA IDENTIFICATION NUMBER: 245375 ER OR SUPPLIER RK HEALTH CARE CENTER 245375 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SECULATORY OR LEC IDENTIFYING INFORMATION) EDUCTION SHORMATION SECULATORY OR LEC IDENTIFYING INFORMATION SECULATORY OR LEC IDENTIFYING INFORMATION SECULATORY OR LEC IDENTIFYING INFORMATION) Intue of the spare bed so they us these keeping it in the resident's room. I verified the facility currently had empty is which were not being used by any lents but stated the facility needed to keep a rooms available for any new admission. I verified the root objut used by any lents but stated the facility needed to keep a rooms available for any new admission. I verified the facility needed to keep a rooms available for any new admission. I verified the facility needed to keep a rooms available for any new admission. I verified the facility methers regarding equests to have the extra bed. It in R6's room. SW-A stated she had en to R8 and her family members regarding equests to have the extra bed removed. SIG(C)(1)(III), (C)(2) - (2) - (3) STIGATE/REPORT GATIONS/INDVIDUALS Facility stated the facility of the of the fact alleged or conclusion at or insappropriation of their property; at finding entered into the State nurse aide of the facts alleged or conclusion set forth in the statements of deficienc

RM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

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		AND HUMAN SERVICES				FORM	. 01/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING	;		12/	20/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RECENTER		1 7	142 NORTH FIRST STREET WAITE PARK, MN 56387		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ca The facility must ha violations are thoro prevent further pote investigation is in pr The results of all inv to the administrator representative and with State law (inclu- certification agency incident, and if the a appropriate correcti	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported or his designated to other officials in accordance uding to the State survey and) within 5 working days of the alleged violation is verified ve action must be taken.	F	225	 Resident incidents and suspected abuse will be reported to DNS/ED with timely matter. All incident reports will be scanned emailed to DNS/ED/nurse consultar an/or designee within a timely manner for review when unavailable in the building DNS/ED or designee will determine if incident/allegation is reportable to state agent and initiate investigation felt necessary. Education regarding vulnerable adult policy w be provided to all staff January 24, 2014. The ED/DNS and/or he designee will audit all incident reports and grievance/concern form one month. 	e nt , l cy as /ill by	
	by: Based on interview facility failed to ensu- neglect were thorou- were taken to prote investigation was co reported to the adm (SA) immediately for	NT is not met as evidenced and document review, the ure allegations of abuse and ughly investigated, actions ct residents until an ompleted and allegations were inistrator and state agency or 4 of 7 residents (R6, R32, wed with allegations of abuse			 6. The data collected will presented to the QA Committee by the ED. data collected will be reviewed/discussed at f monthly QA meeting. A this time the QA Comm will make the decision/recommendati 	The he At ittee	•
	or neglect.	wea with anegations of abuse			regarding any follow-up studies.		
	R6 reported to the f	acility that a staff member had			Completion date: January 24, 201	4	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:6U1311		Fa	cility ID: 00643 If continuation	n sheet Pa	age 18 of 120

	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245375	B. WING		•	12/2	20/2013
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA			W	AITE PARK, MN 56387	TION	(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	⊍LD BE	(X5) COMPLETION DATE
F 225	been rough with he member no longer However, the facilit allegation of abuse R6 until the allegati immediately report R6's quarterly Minit 10/15/13, identified impairment and sha assistance for all a During interview or stated a "couple we social worker that n rough with her whe not want her provid stated NA-A contin night." R6 stated th spoken to NA-A, w they continued to b During interview or member (FM)-J sta registered nurse (F with R6 and did no for the resident am had spoken to her NA-A, and she cor resident. During interview of director of nursing voice mail on 11/30 NA-A being rough interviewed R6 and NA-A working with	nge 18 r. R6 requested that staff provide cares for her. y did not investigate the , implement efforts to protect ion was investigated, or the incident to the SA. mum Data Set (MDS) dated her with no cognitive e required extensive from staff ctivities of daily living (ADLs). n 12/16/13, at 4:20 p.m. R6 eeks" ago she had told the hursing assistant (NA)-A was en providing cares and she did ding cares to her anymore. R6 ued to take care of her "at he facility told her they had ho denied the allegation, so et NA-A care for her. n 12/16/13, at 4:30 p.m. family ated she had spoken to RN)-A about NA-A being rough t want NA-A to provide cares y longer. FM-J stated no one regarding her concerns with ntinued to provide cares to the n 12/17/13, at 12:05 p.m. (DON) stated FM-J left her a D/13, regarding concerns of with R6. The DON stated they d she stated she did not feel afraid. he had not heard any other		225			
	reports from staff r 567(02-99) Previous Version	egarding NA-A or complaints	11	Fa	Acility ID: 00643 If continu	uation sheet F	Page 19 of 120

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	IMENT OF HEALTH						-	FORM	: 01/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SI IDENTIFICATIO	UPPLIER/CLIA	1		LE CONSTRUCTION			E SURVEY IPLETED
		245	375	B. WING			_	12	20/2013
NAME OF I	PROVIDER OR SUPPLIER	L		· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STA			
STERLIN	IG PARK HEALTH CA	RE CENTER				142 NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFI TAG		PROVIDER'S PLA (EACH CORRECTIVE CROSS-REFERENCED DEFIC	EACTION SHOULD) BE	(X5) COMPLETION DATE
	from family or reside the allegation of sta investigated or repor- During interview on stated FM-J came to and said that NA-A night." RN-A stated stated she was not did not report this to investigation becaus complaint." Although R6 and FM about NA-A being ro was not thoroughly SA, nor did the facill longer receiving car R32 had several fall being followed. The reported to the SA a R32's quarterly MDS resident had modera required extensive a eating, and was free R32's care plan date is at risk for falls rela with behavioral distu decisions, and need toileting. Had fall on and pelvic ring fractu due to fall 9/17/13." were "Anti-rollback r prevent any falls h toileting more than u before meals, and w	ents about her. ff abuse were r pred to the SA. 12/17/13, at 8: o her "about a r was "rough with she talked to N rough with the re- investigated or ity ensure R6's e from NA-A was s when the card a falls were not s alleged negle S dated 9/26/13 ate cognitive images ated to history of ribance, poor sa for assist with a 5/1/13 with rig urbance, poor sa for assist with a 5/1/13 with rig urbance, not s asked not to pon rise, HS (h rith staff assisted 12/17/13, at 8: o her "about a r o her "about a r o her "about a r ated to history of a saked not to pon rise, HS (h rith staff assisted o the same a solution o her a soluti	10 p.m. RN-A month ago" n [R6] last VA-A and she resident. RN-A ie up an ave a "specific fic complaints reported to the request of no as honored. e plan was not investigated or act. , identified the pairment, ADLs except ent of bladder. structed, "[R32] of Parkinson's afety ADLs and ht hip fracture cure 9/20/13 erventions vheelchair to be offered our sleep), d	F 2					
DRM CMS-256	7(02-99) Previous Versions (Dbsolete	Event ID: 6U1311		Fac	cility ID: 00643	If continuation	n sheet Pa	ae 20 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245375	B. WING			12/2	20/2013
	PROVIDER OR SUPPLIER	RECENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET /AITE PARK, MN 56387	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	to TABS alarm place room close to nursi frequent monitoring product on top of w sliding out of wheel pedals when not be like phone placed of morning to ease ac her reach when in The current NA wo instructed staff to " when displaying por meals fall preven provide gentle cues wheelchair. If in ro table over legs, use Reposition every 2 Review of R32's in were not consisten as follows: 3/4/13- 9:20 p.m. " floor of her room n that resident had b previously and slid wheelchair found of Resident was last place nonskid pad prevent her from s future." During interview of stated the Dysum be in the resident's intervention impler 2/18/13. DON stat investigation as to R32's wheelchair a	went falls family is opposed sement for fall notification ing station to facilitate more of or self-transfers non-slip theelchair cushion to prevent ichair, remove wheelchair bing propelled by staff would on bed after bed is made in ccess ensure remote is within her room" rksheet dated 12/17/13, assist resident to lie down oor posture and between tion: If walking independently s. Do not force to sit in om alone assure over bed e side cushion when leaning. -3 [two to three] hours." cident reports identified staff tly following the care plan were Resident was found on the ext to her closet. It appeared een in her wheelchair out of wheelchair as lirectly behind resident. toileted at 2:30 p.m Staff did in resident's wheelchair to liding out of wheelchair in the n 12/17/13, at 11:00 a.m. DON non-slip pad was supposed to a wheelchair as that was the nented after the prior fall on ted there was no further why the Dysum was not in according to the plan of care ial neglect of healthcare		225			

)RM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 21 of 120

	IMENT OF HEALTH RS FOR MEDICARE							FORM	: 01/10/20 APPROV . 0938-03	ED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S		1		PLE CONSTRUCTION			E SURVEY IPLETED	
		24	5375	B. WING				12	20/2013	
NAME OF I	PROVIDER OR SUPPLIER				ļ	STREET ADDRESS, CITY, STAT	E, ZIP CODE			
OTEDLU					,	142 NORTH FIRST STREET				
STERLIN	IG PARK HEALTH CA	RECENTER			1	WAITE PARK, MN 56387				
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	IENCIES	ID		PROVIDER'S PLAN	OF CORRECTION	1	(X5)	
PRÉFIX	(EACH DEFICIENCY			PREFI		(EACH CORRECTIVE			COMPLETIC	N
TAG	REGULATORY OR LS	SC IDENTIFYING IN	FORMATION)	TAG		CROSS-REFERENCED		GATE	Ditte	
				<u> </u>						
F 005		04								
F 225		-		F 2	25					
	3/13/13- 3.15 p.m. "									
	room on her hands									
	gently slipped off he					•				
	knees when she wa									
	up" There was no									
	cushion or Dysum w summary of the fall									
	[Nurse Practitioner (
	ordered a chest X-ra									
	due to increased co									
	sounds. This reveal									
	broken ribs on the le									
	increased leaning an									
	This is being addres									
	Review of the chest	X-ray dated 3/	14/13,							
	indicated R32 had "f									
	through sixth ribs."									
	the X-ray by an unkr									
	3/14/13, a message									
	and NP. On 3/15/13									
	faxed a copy of the r									
	NP. There was no in							4		
	identified how R32 re									
	the left side, nor was unknown source of t		u or the							
1	During interview on '		$\cdot 00$ a m the	•						
	DON stated after the									
	R32 and ordered a c									
	decreased breath so									
	X-ray revealed R32 I									
	however, the facility									
	communication with									
	regarding R32's brok									
	was no further invest									
	was there any furthe									
	anti-slip pad not bein									
	verified this should he	ave been repo	rted to the SA							
	and it was not.		and the start of t							
	3/18/13- 5:00 p.m. "F		buna iying on							
ORM CMS-256	7(02-99) Previous Versions O	bsolete	Event ID: 6U1311		Fac	ility ID: 00643	If continuation	sheet Pa	ge 22 of 12	20

DEPART	MENT OF HEALTH	AND HUMAN SERVICES						0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					(X3) DATE	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		E CONSTRUCTION		COME	PLETED
		245375	B. WI				12/2	20/2013
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, 5 42 NORTH FIRST STRE			
STERLIN	G PARK HEALTH CA	RE CENTER			VAITE PARK, MN 56			
0121(2						PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PR	id Refix Tag	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHO	ULD BE	COMPLETION DATE
				F 225				
F 225	Continued From pa	age 22		F 220				
	toileted was 'after li	floor of her roomLast time unch.' Resident was dry at	9					
	time of fall."	n 12/17/13, at 11:00 a.m. DC	N					
	stated she was not	sure the specific time R32						
	had last been toilet	ted before the fall on 3/18/1	3,					
	as this was not par	t of the initial incident repor	t					
	investigation, DON	V verified there was not a						
	complete investiga	tion of the fall nor was this	+					
		related to the possible negl	ect					
	of healthcare.	"Resident was found sitting	on					
	3/31/13- 3:45 p.m.	m next to her wheelchair an	d					
	over-furned trav ta	ble Assessed room for	- F					
	placement of items	s resident may be reaching	for,					
	rearranged approp	oriately."						
	During interview or	n 12/17/13, at 11:00 a.m. D(DN					
	stated she did not	know what the resident was	;		```			
	attempting to do no	or was she sure how the						
	resident's room wa	as arranged prior to the fall a	15					
	this wasn't part of t	the investigation. The DON as done with staff to ensure	<u>م</u>					
	R32's call light was	s within reach, however, she		•				
J	was unable to veri	fy why this education was d	one					
	as she was not su	re if the resident had her ca	11					
	light near her at the	e time of her fall. DON veri	fied					
	this was not thorou	ughly investigated or reporte	ed to					
	the SA related to n	ot following R32's care plan	l.					
	5/1/13- 6:45 a.m. "	Resident was found lying of	n					
	her right side, up a	against the closet. Resident ort what occurred or what sh						
	was unable to repu	ior to fall last toileted at 5:	30					
	a m and was cont	inent at time of fall Reside	ent					
	complained of righ	t hip pain." The facility						
	contacted the phys	sician to obtain an X-ray wh	ich					
	displayed a hip fra	cture and pelvis displaceme	ent.					
	R32 was transferre	ed to the hospital for surger	y.				•	
	The facility interve	ntion after this fall was "ass	ure					
		with appropriate items she n	lidy					
ORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID: 6	5U1311	Fa	acility ID: 00643	If continu	Jation sheet P	age 23 of 120

NO HUMAN SEDVICES

PRINTED: 01/10/2014 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/10/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY APLETED
		245375	B. WING	÷		12	20/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RECENTER			142 NORTH FIRST STREET WAITE PARK, MN 56387	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	a "right intertrochan roughly 6 mm (millir Fractures of the righ rami are again note displacement comp associated sacral al not identified with ce During interview on stated the interventi kept the resident's 'i stated the investigal items were placed in she fell on 5/1/13 ar reported to the SA. 6/1/13- 11:00 a.m. " sitting on her bottom on her elbows. Res self-transfer and sta floorResident was was incontinent at ti offered toileting even provided to NA." Th where the resident s cushion was in the r During interview on stated she was not s Dysum was on her w was not part of the faverified this should her ensure the plan of ca was not reported to 6/16/13- 5:15 p.m. "I her right side with le attempting to reach for out of her wheelchai going to throw a piece	zine, etc.)." ated 5/1/13 identified R32 had teric hip fracture with up to meters) of displacement at superior and inferior pubic d. There is increased ared to prior exam. An la fracture is suspected but ertainty" 12/17/13 at 11:00 a.m. DON on was to make sure staff tems' within reach. DON tion did not include where in the residents room when ad the fall with injury was not Resident was found by staff in near the bathroom, leaning ident attempted to ted she slid very slowly to the last toileted at 9:00 a.m., and me of fall Resident is to be ry hour, re-education was be investigation did not identify slid from and if the anti-slip esident's wheelchair. 12/17/13, at 11:00 a.m. DON sure if the resident's anti-slip vheelchair cushion as that all investigation. DON have been investigated to are was being followed. This	Fź				

DEPARTMENT OF HEALTH	AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION			E SURVEY PLETED
	245375	B. WING				12/2	20/2013
NAME OF PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIF	CODE	•	
STERLING PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET /AITE PARK, MN 56387			
(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
ambulance was ca injuries. Educated brakes for the when this time." During interview or stated anti-lock bray wheelchair after the she was not sure if residents chair as f investigation. This 9/17/13- 4:40 p.m. floor by the NA. SI grasping her left hi severe painambu resident was transp hospital. Prior to h reported that she for room. She entered back in her wheelc something the resid and stated, 'I need nothing was noted the floor nurse ask and resident stated here' Family had placed on resident mobilityResident applied to her whee and followed correct facility from the hos Review of a Traum 9/17/13, indicated I identified, "Evidenci new [acute] fracture ramus and parasyr pubic bone." R32 v During interview or	er right side of her body lled no fractures or other family on use of anti-roll back elchair which were applied at n 12/17/13, at 11:00 a.m. DON kes were added to R32's e fall on 6/16/13. DON stated the anti-slip Dysum was in the his was not part of the fall was not reported to the SA. "Resident was found on the ne was lying on her back and p, groin area and expressing lance was contacted and borted to the St. Cloud er fall activity staff had bund resident standing in her d the room and had resident sit hair, and asked if there was dent needed. Resident pointed that over there,' though to be presentWhen found on ed what she was trying to do I she was trying to 'get out of requested that no alarms be as to not limit her has anti-roll back brakes elchair, toileting plan in place ctty." Resident returned to the	F	225				

RM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 25 of 120

EPARTMENT OF HEALTH AND HUMAN SERVICES O ENTERS FOR MEDICARE & MEDICAID SERVICES O (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
LINTEROTOR CONTINUED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	
B. WING	12/20/2013
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET	
TERLING PARK HEALTH CARE CENTER WAITE PARK, MN 56387 ID PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDENCITIVE ACTION SHOULI?REFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULI?REFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXCROSS-REFERENCED TO THE APPROFTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGDEFICIENCY)	UDE
F 225 Continued From page 25 place after the fall with fracture on 9/17/13, nor did the facility investigate the fall to ensure the room was set up according to R32's care plan. This was not reported to the SA. 11/9/13- 8:05 p.m. "Recident was found on the floor by NA sitting on the floor. Resident was sitting in front of her wheelchair Staff did question if resident had slipped out of her wheelchair due to proximity of wheelchair behind the resident. Dycem non-slip material placed in residents wheelchair post fall." During interview on 12/17/13 at 11:00 a.m. DON stated the Dycem non-slip material which was ordered on 2/18/13, was never discontinued, and she was unsure why it was not in R32's wheelchair on 11/9/13. DON verified staff were not following R32's care plan to prevent falls if the Dycem was not in place and this should have been reported to the SA but it was not as possible neglect. Although R32 had several falls related to lack of staff following reported to the administrator immediately, or to the SA. R48 had fallen multiple times while her care plan was not reported to the administrator immediately, or to the SA. R48's admission MDS dated 10/18/13, included diagnoses of hip fracture, hypertension and dementia. The MDS indicated R48 had severe cognitive impairment, required extensive assistance for all ADLs and had fallen prior to admission. The fall Care Area Assessment (CAA) dated 10/16/13, included R48 was at risk for falls related to poor balance and cognitive deficit.	ution sheet Page 26 of 12

ORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page

		AND HUMAN SERVICES				O		APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY PLETED
		245375	B. WING				12/2	20/2013
NAME OF I	PROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STAT	E, ZIP CODE	•	
STERLIN	IG PARK HEALTH CA				42 NORTH FIRST STREET /AITE PARK, MN 56387			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XI	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPF	BE	(X5) COMPLETION DATE
F 225	R48's care plan dat is at risk for falls r/t cognitive loss with incont [incontinent] analgesia use, and directed staff to ens her bed kept in a lo anticipated, and to cause of any falls. R48's Resident Inc at 11:25 a.m. indica investigation report of bed, and staff sh "appropriate height stand up from low b walker in reach so	ted 10/24/13, included, "[R48] [related to] history of, impaired decision making, , new to environment, daily osteoporosis." The care plan sure her call light was in reach, w position, her needs attempt to determine the ident Report dated 10/27/13, ated R48 had fallen. The fall indicated she had slipped out rould now leave the bed at the so resident is not trying to bed position, and to assure if resident attempts to get up new approach was added to	F	225				
	12:00 a.m. indicate been in the lowest height" as indicated was not reported to reportable incident. administrator had n three days later. W at 2:50 p.m. the DC bed at appropriate not been followed, of a low bed, this st the administrator an not. R48's Resident Inci 1:30 a.m. indicated	ident Report dated 11/2/13, at d R48 had fallen, her bed had position, not the "appropriate d. The report indicated this o the SA because it was not a The report also indicated the not been notified until 11/5/13, /hen interviewed on 12/19/13, DN stated R48's care plan of height and walker by bed, had R48 fell attempting to get out hould have been reported to nd SA immediately, but had ident Report dated 11/13/13, at R48 had fallen while trying to be Incident Investigation						
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U131	1	Fac	ility ID: 00643	If continuation	sheet Pa	age 27 of 120

PRINTED: 01/10/2014

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		AND HUMAN SERVICES				FOR	D: 01/10/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
		245375	B. WING			12	2/20/2013
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RECENTER			42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pay indicated her walker were re-educated of The incident report if had not been notifie later, and the SA ha was not a reportable When interviewed of DON stated the adm have been notified in plan had not been for a fall. R48's Resident Incide toilet, in the bathrood Investigation indicate toilet, in the bathrood Investigation indicate not leaving R48 unati impulsive behavior. reported to the administrator DON stated it is the unsteady or cognitive in the bathroom. Sh aide responsible at the stated this should has administrator and the R11's care plan was while left unattended The incident was not administrator or the S R11's Resident Incide	ge 27 r had not been in reach. Staff n leaving walker within reach. indicated the administrator d until 11/15/13, two days d not been notified because it e incident of abuse or neglect. n 12/19/13, at 2:50 p.m. the ninistrator and SA should mmediately, because the care ollowed and R48 had suffered dent Report dated 12/10/13, ed R48 had been left on the m alone. The Incident ed staff were re-educated on ttended on the toilet due to The incident was not nistrator until 12/11/13, the ot been reported to the SA. n 12/19/13, at 2:50 p.m. the facility policy not to leave ely impaired residents alone e had re-educated the nurse he time of the fall. The DON ve been reported to the e SA immediately. not followed when R11 fell on a commode in her room. immediately reported to the	F 2	25			
1 1	her room. She had b was found ten minute	een on the commode and es later on the floor. The nmediate intervention of,					

)RM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 28 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			E SURVEY PLETED
		245375	B. WING			•	12/	20/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STAT	E, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			AITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 225	on commode." The reportable (abuse of administrator was in until the following of R11's annual MDS was moderately co- extensive assistant and bed mobility. had no falls since to 10/9/13, and she we bladder. R11's care plan da was at moderate ri unaware of her saf loss, psychotropic problems, bladder attempts to self-tra of one with transfe During interview 12 verified R11 had fa following her care of unattended on the she did not notify to immediately becaut reportable incident A policy entitled Re and Procedure, da as, "Failure to provine Reporting of Accido "[The facility] shall environment remain as possible, and the	not leave resident unattended e report indicated it was not a br neglect) issue and the not notified about the incident lay, on 11/5/13. 6 dated 10/16/13, indicated she gnitively intact and required ce with transfers, ambulation The MDS also indicated R11 he prior assessment on vas frequently incontinent of ated 10/13/16, indicated she sk for falls related to being ety needs, short term memory medication use, gait/balance urgency with incontinence, insfer and her need for assist rs and toileting. 2/19/13, at 10:30 a.m. the DON illen as a result of staff not plan of not leaving her commode. The DON stated he administrator or the SA ise she was not aware it was a	F2	225				

RM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 29 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	2: 01/10/2014 1APPROVED 2: 0938-0391
TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		IE SURVEY MPLETED
		245375	B. WING			12	/20/2013
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	prevent accidents." after any allegation unexplained injury, be re-assigned, pla- or suspended pend resident's protection would be contacted 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle and misappropriation This REQUIREMEN by: Based on interview facility failed to impl policy which include allegations of abuse protect residents un neglect allegations v immediate reporting administrator and st residents (R6, R32, allegations of abuse Findings include: A facility policy entit Policy and Procedur neglect as, "Failure necessary to avoid Reporting of Accide	The policy further indicated of abuse, neglect, or the alleged perpetrator would ced under direct supervision ing investigation for the n. The administrator and SA immediately. P/IMPLMENT ETC POLICIES velop and implement written ures that prohibit ect, and abuse of residents n of resident property. IT is not met as evidenced and document review, the ement an abuse prohibition of thorough investigations of and neglect, actions taken to til investigations of abuse and were complete, and of allegations to the ate agency (SA), for 4 of 7 R48 and R11) reviewed with		225	 F 226 The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the forth facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provision of state and federal law require Without waiving the foregoing statement, the facility states with respect to: Resident incidents and suspected abuse will be reported to DNS/ED with timely matter. All incident reports, including medication err will be reviewed by the DNS and ED /or designed for possible Vulnerable Adult reporting accordin state and federal guideli Education regarding vulnerable adult policy we be provided to all staff b January 24, 2014. 	loes an rruth ns tion ons it. n nin a ors ee g to nes. vill y	

Facility ID: 00643

		AND HUMAN SERVICES			· •	FORM A	APPROVED 0938-0391
ENTER TEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE	
) PLAN O	CORRECTION		B. WING			12/2	20/2013
		245375		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				NORTH FIRST STREET		
TERLIN	G PARK HEALTH CA	RE CENTER		WA	AITE PARK, MN 56387	NI	(X5)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	0 0	COMPLETION DATE
F 226	accident hazards a resident receives a assistive devices t policy further indic abuse, neglect, or perpetrator would direct supervision investigation for th administrator and immediately. R6 reported to the been rough with h member no longe However, the faci allegation of abus R6 until the allega immediately repo accordance with policy. R6's quarterly Mi 10/15/13, identifie impairment and s assistance for all During interview stated a "couple social worker tha rough with her w not want her pro- stated NA-A con night." R6 stated spoken to NA-A, they continued to	environment remains as free of as possible, and that each adequate supervision and to prevent accidents." The sated after any allegation of unexplained injury, the alleged be re-assigned, placed under or suspended pending the resident's protection. The SA would be contacted e facility that a staff member had the resident's protection. The SA would be contacted e facility that a staff member had the requested that staff or provide cares for her. Ity did not investigate the se, implement efforts to protect ation was investigated, or rt the incident to the SA in the facility's abuse prohibition nimum Data Set (MDS) dated ed her with no cognitive she required extensive from staff activities of daily living (ADLs). on 12/16/13, at 4:20 p.m. R6 weeks" ago she had told the at nursing assistant (NA)-A was hen providing cares and she did viding cares to her anymore. Re tinued to take care of her "at I the facility told her they had who denied the allegation, so o let NA-A care for her. con 12/16/13, at 4:30 p.m. family stated she had spoken to	f f f	226 -	incident reports and grievance/concern for one month. 5. The data collected will be reviewed/discussed monthly QA meeting this time the QA Corr will make the decision/recommend regarding any follow studies. Completion date: January 24, 5	ill be D. The at the At nmittee lation -up 2014	et Page 31 of 12

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		AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING	i		12/	20/2013
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET IAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	with R6 and did not for the resident any had spoken to her	age 31 RN)-A about NA-A being rough t want NA-A to provide cares v longer. FM-J stated no one regarding her concerns with tinued to provide cares to the	F:	226	· · · ·		
	director of nursing voice mail on 11/30 NA-A being rough interviewed R6 and NA-A working with DON also stated sh reports from staff re from family or resid	12/17/13, at 12:05 p.m. (DON) stated FM-J left her a 0/13, regarding concerns of with R6. The DON stated they I she stated she did not mind her and she did not feel afraid. he had not heard any other egarding NA-A or complaints lents about her. DON verified aff abuse were not thoroughly borted to the SA.			· · · · · · · · · · · · · · · · · · ·		
	stated FM-J came and said that NA-A night." RN-A stated stated she was not did not report this to	a 12/17/13, at 8:10 p.m. RN-A to her "about a month ago" was "rough with [R6] last d she talked to NA-A and she rough with the resident. RN-A o anyone or write up an use she didn't have a "specific				·	
	about NA-A being r was not thoroughly SA, nor did the faci	M-J made specific complaints ough with the resident, this investigated or reported to the lity ensure R6's request of no re from NA-A was honored.			· •		
	being followed. The	lls when the care plan was not e falls were not investigated or as alleged neglect as per the					
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1311		Faci	lity ID: 00643 If continuation	on sheet Pa	age 32 of 120

	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOF	ED: 01/10/2014 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED
		245375	B. WING				12/20/2013
NAME OF F	PROVIDER OR SUPPLIER	,			REET ADDRESS, CITY, STATE, ZIP COL 2 NORTH FIRST STREET	JE	
STERLIN	IG PARK HEALTH CA	RE CENTER		•	AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 32	F:	226			
	resident had moder required extensive eating, and was free R32's care plan dat is at risk for falls rel with behavioral dist decisions, and need toileting. Had fall of and pelvic ring fract due to fall 9/17/13." were "Anti-rollback prevent any falls It toileting more than before meals, and v repositioning to pre- to TABS alarm plac room close to nursi frequent monitoring product on top of w sliding out of wheel pedals when not be like phone placed o morning to ease ac her reach when in h The current NA wor instructed staff to "a when displaying po- meals fall prevent provide gentle cues wheelchair. If in roo table over legs, use Reposition every 2- Review of R32's ind were not consistent as follows: 3/4/13- 9:20 p.m. "F	vent falls family is opposed ement for fall notification ng station to facilitate more for self-transfers non-slip heelchair cushion to prevent chair, remove wheelchair ing propelled by staff would n bed after bed is made in cess ensure remote is within					

ORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 33 of 120

DEPART		AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY PLETED
		245375	B. WING		•		12/:	20/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STAT	E, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			2 NORTH FIRST STREET AITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPI	BE	(X5) COMPLETION DATE
F 226	Continued From partial tresident had be previously and slid wheelchair found d Resident was last to place nonskid pad prevent her from sl future." During interview or stated the dysum no be in the resident's intervention implem 2/18/13. DON state investigation as to R32's wheelchair anor was the potent reported to the SA. 3/13/13- 3:15 p.m. room on her hands gently slipped off h knees when she with up" There was no cushion or dysum of the fall [Nurse Practitioner ordered a chest X-due to increased cosounds. This reveable to the sounds of the sounds of the sounds of the sounds. This reveable to the sounds of the sounds of the sounds of the sounds. This reveable to the sounds of the sounds of the sounds of the sounds of the sounds. This reveable to the sounds of the sounds of the sounds of the sounds of the sounds. This reveable to the sounds of the sounds of the sounds of the sounds of the sounds. This reveable to the sounds of the sounds	ige 33 een in her wheelchair out of wheelchair as irectly behind resident. oileted at 2:30 p.m Staff did in resident's wheelchair to iding out of wheelchair in the 12/17/13, at 11:00 a.m. DON on-slip pad was supposed to wheelchair as that was the nented after the prior fall on ed there was no further why the dysum was not in ccording to the plan of care ial neglect of healthcare		226	DEFIC	ENGY)		
	through sixth ribs." the X-ray by an un 3/14/13, a messag and NP. On 3/15/1 faxed a copy of the NP. There was no	Handwritten on the bottom of known facility nurse on e was left with R32's physician 13, it was written the facility had e results to R32's physician and investigation in the record that received four fractured ribs on						

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If continuation sheet Page 34 of 120

DEPART							APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		245375	B. WING			12/2	20/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	G PARK HEALTH CA	RE CENTER			2 NORTH FIRST STREET AITE PARK, MN 56387		
		·			PROVIDER'S PLAN OF CORRECTION	1	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	unknown source of During interview on DON stated after th R32 and ordered a decreased breath s X-ray revealed R32 however, the facility communication with regarding R32's brow was no further inve- was there any furth anti-slip pad not be verified this should and it was not. 3/18/13- 5:00 p.m. ¹ her left side on the toileted was 'after lut time of fall." During interview on stated she was not had last been toilete as this was not part investigation. DON complete investigat reported to the SA no of healthcare. 3/31/13- 3:45 p.m. ¹ the floor in her room over-turned tray tak placement of items rearranged appropri During interview on stated she did not k attempting to do no resident's room was this wasn't part of the stated education was	is the SA notified of the the fracture. 12/17/13, at 11:00 a.m. the re fall on 3/13/13, the NP saw chest X-ray related to ounds. She stated the chest had four broken ribs; had no investigation or the NP or the physician oken ribs. DON stated there stigation of the broken ribs nor er information regarding the ing in R32's wheelchair. DON have been reported to the SA "Resident was found lying on floor of her roomLast time unch.' Resident was dry at 12/17/13, at 11:00 a.m. DON sure the specific time R32 ed before the fall on 3/18/13, t of the initial incident report I verified there was not a ion of the fall nor was this related to the possible neglect "Resident may be reaching for, riately." 12/17/13, at 11:00 a.m. DON know what the resident was r was she sure how the s arranged prior to the fall as he investigation. The DON as done with staff to ensure		226		n shoef P	209. 35 of 120
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1311	I	Fac	ility ID: 00643 If continuatio	n sheet P	age 35 of 120

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· · · · · · · · · · · · · · · · · · ·		FORM	01/10/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245375	B. WING		<u></u>		12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP	CODE		
	G PARK HEALTH CA				2 NORTH FIRST STREET			
SIERLIN	G PARK HEALTH CA				AITE PARK, MN 56387	PRESTO		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 226	was unable to verifi as she was not sur light near her at the this was not thorou the SA related to no 5/1/13- 6:45 a.m. "I her right side, up at was unable to repo was trying to do pri a.m. and was conti complained of right contacted the phys displayed a hip frace R32 was transferrer The facility interver resident is set up w need (snack, maga The X-ray results of a "right intertrochan roughly 6 mm (milli Fractures of the rig rami are again note displacement comp associated sacral a not identified with of During interview or stated the interven kept the resident's stated the interven kept the resid	within reach, however, she y why this education was done e if the resident had her call a time of her fall. DON verified ghly investigated or reported to of following R32's care plan. Resident was found lying on gainst the closet. Resident rt what occurred or what she or to fall last toileted at 5:30 nent at time of fall Resident thip pain." The facility ician to obtain an X-ray which of the hospital for surgery. Attorn after this fall was "assure vith appropriate items she may azine, etc.)." lated 5/1/13 identified R32 had herric hip fracture with up to meters) of displacement th superior and inferior pubic ed. There is increased bared to prior exam. An ala fracture is suspected but certainty" n 12/17/13 at 11:00 a.m. DON tion was to make sure staff 'items' within reach. DON ation did not include where in the residents room when and the fall with injury was not	F	226				
)RM CMS-2	was incontinent at 567(02-99) Previous Versions	time of fall Resident is to be	1	Fac	lity ID: 00643	continuatio	on sheet F	Page 36 of 120

		AND HUMAN SERVICES			·	FOR	D: 01/10/2014 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		245375	B. WINC	Э_		1	2/20/2013
NAME OF I	PROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE		
					142 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	ARE CENTER			WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	offered toileting ever provided to NA." T where the resident cushion was in the During interview on stated she was not dysum was on her was not part of the verified this should ensure the plan of of was not reported to 6/16/13- 5:15 p.m.' her right side with le attempting to reach out of her wheelchai going to throw a pie of wheelchair. Was from left hip to uppe ambulance was call injuries. Educated brakes for the wheel this time." During interview on stated anti-lock brat wheelchair after the she was not sure if residents chair as th investigation. This 9/17/13- 4:40 p.m." floor by the NA. Sh grasping her left hip severe painambul resident was transp hospital. Prior to her reported that she fo room. She entered	ery hour, re-education was the investigation did not identifi- slid from and if the anti-slip resident's wheelchair. 12/17/13, at 11:00 a.m. DON sure if the resident's anti-slip wheelchair cushion as that fall investigation. DON have been investigated to care was being followed. This	y	22			
	something the resid	ent needed. Resident pointed that over there,' though	1				
DRM CMS-250	67(02-99) Previous Versions	Obsolete Event ID: 6U13		F	Facility ID: 00643 If continua	ation sheet	Page 37 of 120

DRM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 37 of 120

		AND HUMAN SERVICES			FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245375	B. WING		12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	RE CENTER		WAITE PARK, MN 56387		
(X4)1D PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	the floor nurse ask and resident stated here' Family had placed on resident mobilityResident applied to her whee and followed correct facility from the hos Review of a Traum 9/17/13, indicated B identified, "Evidence new [acute] fracture ramus and parasyr pubic bone." R32 v During interview or stated the facility d place after the fall v did the facility inves room was set up ac This was not report 11/9/13- 8:05 p.m. floor by NA sitting of sitting in front of he question if resident wheelchair due to p the resident. Dyce residents wheelcha During interview or stated the dycem n ordered on 2/18/13 she was unsure why wheelchair on 11/9, not following R32's dycem was not in p	to be presentWhen found on ed what she was trying to do I she was trying to 'get out of requested that no alarms be as to not limit her has anti-roll back brakes elchair, toileting plan in place otly." Resident returned to the spital on 9/19/13. a Admission note dated R32 had a pelvis X-Ray which ee of old right hip fractures with es of the left inferior pubic mphyseal region of the left was admitted to the hospital. n 12/17/13 at 11:00 a.m. DON id not put new interventions in with fracture on 9/17/13, nor stigate the fall to ensure the ccording to R32's care plan. ted to the SA. "Resident was found on the on the floor. Resident was r wheelchair Staff did had slipped out of her proximity of wheelchair behind m non-slip material placed in	F 226			
·	Although R32 had	several falls related to lack of esidents care plan, the falls				

)RM CMS-2567(02-99) Previous Versions Obsolete

Event ID:6U1311

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Facility ID: 00643

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If continuation sheet Page 38 of 120

		AND HUMAN SERVICES					APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED	
		245375	B. WING		:	12/20/2013		
	PROVIDER OR SUPPLIER	RECENTER	I	14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387	÷		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 226	Continued From pa were not thoroughly the SA.	ge 38 / investigated or reported to	F	226				
	was not followed by care was not repor	tiple times while her care plan / staff. This neglect of health ted to the administrator he SA as per the facility's						
	diagnoses of hip fra dementia. The MD cognitive impairme assistance for all A admission. The fal (CAA) dated 10/16	DS dated 10/18/13, included acture, hypertension and S indicated R48 had severe nt, required extensive DLs and had fallen prior to I Care Area Assessment /13, included R48 was at risk poor balance and cognitive						
	is at risk for falls r/f cognitive loss with incont [incontinent] analgesia use, and directed staff to en her bed kept in a lo	ted 10/24/13, included, "[R48] [related to] history of, impaired decision making, , new to environment, daily osteoporosis." The care plan sure her call light was in reach, w position, her needs attempt to determine the						
	at 11:25 a.m. indica investigation report of bed, and staff sh "appropriate height stand up from low walker in reach so	ident Report dated 10/27/13, ated R48 had fallen. The fall t indicated she had slipped out hould now leave the bed at the so resident is not trying to bed position, and to assure if resident attempts to get up new approach was added to 0/27/13.						

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID:6U1311

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Facility ID: 00643

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If continuation sheet Page 39 of 120

DEPART		AND HUMAN SERVICES & MEDICAID SERVICES			~	OM	NTED: 01 FORM AP B NO. 09	PROVED 38-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		245375	B. WING				12/20/	2013
NAME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			REET ADDRESS, CITY, STATE, 2 NORTH FIRST STREET	ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			AITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) DMPLETION DATE
F 226	12:00 a.m. indicate been in the lowest height" as indicated was not reported to reportable incident administrator had r three days later. W at 2:50 p.m. the DO bed at appropriate not been followed, of a low bed, this s the administrator a not. R48's Resident Inc 1:30 a.m. indicated get out of bed. The indicated her walke were re-educated of The incident report had not been notifi later, and the SA h was not a reportab When interviewed DON stated the ad have been notified plan had not been a fall. R48's Resident Inc at 9:20 a.m. indicated indicated her walke were re-educated of the incident report had not been notified plan had not been a fall.	ident Report dated 11/2/13, at d R48 had fallen, her bed had position, not the "appropriate d. The report indicated this of the SA because it was not a . The report also indicated the not been notified until 11/5/13, /hen interviewed on 12/19/13, DN stated R48's care plan of height and walker by bed, had R48 fell attempting to get out hould have been reported to nd SA immediately, but had ident Report dated 11/13/13, at I R48 had fallen while trying to e Incident Investigation er had not been in reach. Staff on leaving walker within reach. indicated the administrator ed until 11/15/13, two days ad not been notified because it le incident of abuse or neglect. on 12/19/13, at 2:50 p.m. the ministrator and SA should immediately, because the care followed and R48 had suffered cident Report dated 12/10/13, ted R48 had been left on the om alone. The Incident ated staff were re-educated on attended on the toilet due to . The incident was not ninistrator until 12/11/13, the not been reported to the SA.		226				

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If continuation sheet Page 40 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/10/2014 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	:	(X3) DATE SURVEY COMPLETED		
		245375	B. WING		1 	12/	20/2013	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S				
STERLIN	IG PARK HEALTH CA	RECENTER	- A	142 NORTH FIRST STRE WAITE PARK, MN 563	87			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPH FICIENCY)	BE	(X5) COMPLETION DATE	
	DON stated it is the unsteady or cognitive in the bathroom. Sl aide responsible at stated this should h administrator and th R11's care plan was while left unattended The incident was not administrator or the facility's abuse proh R11's Resident Incid 5:00 a.m. indicated her room. She had was found ten minur report indicated the "Educated staff to not on commode." The reportable (abuse of administrator was not until the following da R11's annual MDS was moderately cog extensive assistance and bed mobility. Th had no falls since th 10/9/13, and she was bladder. R11's care plan date was at moderate risk unaware of hersafet loss, psychotropic m problems, bladder unit	n 12/19/13, at 2:50 p.m. the facility policy not to leave vely impaired residents alone the had re-educated the nurse the time of the fall. The DON ave been reported to the the SA immediately. The of followed when R11 fell d on a commode in her room. to immediately reported to the SA in accordance with the ibition policy. The Report dated 11/4/13, at she was found on the floor in been on the commode and tes later on the floor. The immediate intervention of, ot leave resident unattended report indicated it was not a neglect) issue and the ot notified about the incident	F 226					
	57(02-99) Previous Versions (Fa	cility ID: 00643	If continuation	sheet Pa		

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			· F(ITED: 01/10 ORM APPR NO. 0938	OVED
CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375				E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED		
		245375	B. WING			12/20/20 ⁻	13
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			PROVIDER'S PLAN OF CORRECTION	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		COMP	(5) LETION ATE	
F 226	Continued From pa of one with transfer	-	F2	226			
F 244 SS=E	During interview 12 verified R11 had fail following her care p unattended on the of she did not notify the immediately becaus reportable incident. 483.15(c)(6) LISTE GRIEVANCE/RECO When a resident or must listen to the vi- grievances and reco and families concel operational decision life in the facility. This REQUIREMEN by: Based on interview facility failed to ens grievances related the potential to affer R12, R20, R13, R2 attended resident of through 11/13. Findings include: Review of the reside from 3/13 through R18, R6, R12, R20	 /19/13, at 10:30 a.m. the DON len as a result of staff not olan of not leaving her commode. The DON stated he administrator or the SA se she was not aware it was a N/ACT ON GROUP DMMENDATION family group exists, the facility ews and act upon the ommendations of residents ming proposed policy and his affecting resident care and NT is not met as evidenced v and document review the ure prompt responses to to staffing concerns. This had ct 7 of 41 residents (R18, R6, 4 and R25) who regularly ouncil meetings from 3/13 ent council meeting minutes 11/13, identified seven resident , R13, R24 and R25 who the council meetings had the 	F	244	F 244 The preparation of the following plar 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 or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Facility protocol for resident council updated 2. Resident council minutes will be reviewed by ED/DNS and/or designee monthly. 3. The data collected will be present to the QA Committee by the DNS. T data collected will be reviewed/discussed at the quarterly of meeting. At this time the QA Commi will make the decision/recommendat regarding any follow-up studies.	ted The QA ittee	

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Facility ID: 00643

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	TMENT OF HEALTH RS FOR MEDICARE							FORM	: 01/10/2014 APPROVED . 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375					E CONSTRUCTION	<u>i</u>		E SURVEY MPLETED
		24	15375	B. WING			12/20/2013		
NAME OF	PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, S			
STERLIN	NG PARK HEALTH CA	RE CENTER				42 NORTH FIRST STREE /AITE PARK, MN 563	1		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFI MUST BE PRECE SC IDENTIFYING I	DED BY FULL	ID PREFIZ TAG	x	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTIC VE ACTION SHOULI ED TO THE APPROP FICIENCY)) BE	(X5) COMPLETION DATE
F 244	Continued From pa	ge 42		F 2	44		: ; ; ; ;		
	The 3/29/13 resider identified concerns facility. Documente too long sometimes	of sufficient sl d concerns in	affing within the cluded, "Wait						
	The 4/26/13 resider did not address the regarding sufficient whether the facility or discussed a plan	previous mon staffing, nor d had responde	th's concern lid they reflect d to the concern,			•			
	The 7/26/13 resider identified a concern timely to a resident's hour and 15 minutes	of staff failure s call light, "1:	e to respond 15 min [one		-				
	The resident counci 8/30/13, identified a leave call lights with minutes did not add concern nor did they discussed a plan for	concern of st in reach of ea ress the previ / reflect if the	aff failure to ich resident. The ous month's facility had						
	The 9/30/13 resider indicated "call lights" not address how the concern or a plan fo	" under old bu e facility had re	siness but did esponded to the						
	The 11/29/13 reside indicated a concern facility. Concerns re- too long to wait." Th Resident Council Me activity director (AD) nursing would evalu- morning interdiscipli implement hourly cu complete a staffing g	of sufficient s gistered includ le Concerns fi eeting sheet fi and nursing, ate the call lig nary team me stomer servic	taffing within the ded, "Call lights rom the lled out by the indicated ht report in eting daily, e rounds, o ensure there						
ORM CMS-25	67(02-99) Previous Versions (Obsolete	Event ID: 6U1311		Facil	lity ID: 00643	If continuation	n sheet Pa	age 43 of 120

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	MENT OF HEALTH	AND HUMAN SERVICES				FORM. OMB NO.	01/10/2014 APPROVED 0938-0391	
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245375	B. WING		-	12/2	20/2013	
	ROVIDER OR SUPPLIER		14	REET ADDRESS, CITY, STA 2 NORTH FIRST STREET AITE PARK, MN 56387				
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECT	ILD BE	(X5) COMPLETION DATE	
F 244	times, and educate planned changes v 12/23/13, twenty fo was received.	ead support during busier e staff. Implementation of the vas to begin the week of our days after the complaint	F 244			I		
	council meetings v 12:56 p.m. R18 sta anywhere from 15 someone to come light]." R18 could occurred. The qua dated 10/31/13, in	nded nine of the nine resident vas interviewed on 12/19/13, at ated, "Sometimes it can take minutes to one hour for [to respond to an activated call not specify when these waits rterly Minimum Data Set (MDS) dicated R18 was cognitively a extensive assist for toileting			•			
·	council meetings v 1:05 p.m. R6 state 15-20 minutes or r after she was assi will tell me to push come back, but th time. Sometimes stated that it made left on the commo these waits occurr day. The quarter indicated R6 was	ded four of the nine resident was interviewed on 12/19/13, at ad she sometimes had to wait more for someone to come sted onto the commode, "They my button and say they will at doesn't happen all of the I have to wait longer." R6 a her feel uncomfortable to be de for that long. She reported red approximately every other y MDS dated 10/22/13, cognitively intact, required nce for toileting and was totally hsfers.					:	
	indicated that whe that was registere meeting, a concer to the appropriate	w on 12/18/13, at 8:58 a.m. AD enever a resident had a concerr d during a resident council n sheet was filled out and giver department for them to ed the concerns registered in	ו	acility ID: 00643	If continu	ation sheet	Page 44 of 120	

)EPARTI	VENT OF HEALTH	AND HUMAN SERVICES			O	FORM A MB NO.	APPROVED 0938-0391
	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		245375	B. WİNG			12/2	20/2013
	ROVIDER OR SUPPLIER			14	REET ADDRESS, CITY, STATE, ZIP CODE 2 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 244	was taken by the f stated in 8/13, a w filled out regarding within residents' re forwarded to nursi educating the staf "24 hour board." / complain about ca lot." During an intervie (DON) on 12/19/1 24 hour communic communicate any asked about the 8 lights and how it v caring for residen shoulders and sta they need to tell th away. On 12/20/13, a co was requested bu 483.15(f)(1) ACT INTERESTS/NEE The facility must of activities desig the comprehensit the physical, mer of each resident. This REQUIREM by: Based on obser	e not addressed and no action acility to resolve the issue. AD ritten concern sheet was not g staff failure to leave call lights each, but was verbally ng, who responded by f and putting the concern on the AD stated she found residents all lights not being answered "a w with the Director of Nursing 3, at 9:26 a.m. she stated the cation board was a tool to issues to the nurses. When 8/13 resident concern about call vas communicated to staff ts, the DON shrugged her ated, "I don't check every time he staff something," and walked omplaint and grievance policy ut not provided by the facility. IVITIES MEET EDS OF EACH RES provide for an ongoing program ned to meet, in accordance with ve assessment, the interests an ntal, and psychosocial well-being	F	244	agreement by the facility of the of the facts alleged or conclu- set forth in the statement of deficiencies. The plan of cor prepared for this deficiency w executed solely because pro of state and federal law requ Without waiving the foregoing statement, the facility states respect to:	cy does be nor an ne truth sions rection vas visions ire it. g with	
		ions Obsolete Event ID:6U1	311	F	Facility ID: 00643 If continu	ation sheet	Page 45 of 12

ORM CMS-2567(02-99) Previous Versions Obsolete

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CENTERS FOR MEDICARE & MEDICARD SERVICES OMM INC DEPINENCE OMM INC DEPINENCE OMM INC DEPINENCE OPMIN INC DEPINENCE OPMIN INC DEPINENCE DEPINENCES OPMIN INC DEPINENCE DEPINENCES DEPINENCES <th>DEPAR</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>FORM</th> <th>01/10/2014 APPROVED 0938-0391</th>	DEPAR						FORM	01/10/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STREET STERLING PARK HEALTH CARE CENTER 12 NORTH FIRST STREET VC41D PREVENCES VELVES (MARK) STREETER VAITE PARK, MN 56337 VAITE PARK, MN 56337 VC41D PREVENCES VELVES (MARK) STREETER VAITE PARK, MN 56337 PROVIDERS PLAN CORECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 00,000 (MAITE PARK, MN 56337 F 248 Continued From page 45 (R32) reviewed for activities, was provided with activities to meet their individual preferences in accordance with the comprehensive resident assessment, including activities which tock place outside of the resident room. F 248 R32's quarterly minimum data set (MDS) dated 9/26/13, identified she had a moderate cognitive impairment and required extensive assistance with activities of adip living (ADLs) except eating. 8. R32's activity care plan dated 10/3/13, indicated she was independent with activity pursuits and did no tattend many group activities per her choice. She also received on to one programing three times a week, which could include visiting, pet therapy, loton, walks, or outdoors. Care plan interventions included a phone to be placed on her bed per her preference, assistance with turning the channel with the idevision, istening to the radio, main, regarding appers as per R22 spectrence. The care plan also indicated R32 was to receive a newspaper delivered to her room daily, R32's likes included reading the newspaper, watching television, listening to the radio, music, taking on the telephone and visiting with family and others. 0ate of Completion: January 24, 2014	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTION MUST BE PRECEDED BY FULL (EACH CORRECTIVE AND OF CORRECTIVE AND O			245375	B. WING	_		12/	20/2013
STERLING PARK HALTH CARE CENTER WAITE PARK, MN 55337 ONLINE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL (EACH DEFICIENCY) PROVIDERS FLAM OF CORRECTION (EACH CORRECTION (EACH CORRECTION) Deficiency (EACH CORRECTION) F 248 Continued From page 45 (R32) reviewed for activities, was provided with activities of the comprehensive resident assessment, including activities which took place outside of the resident room. F 248 F 248 R 22's quarterly minimum data set (MDS) dated 9/26/13, identified she had a moderate cognitive she was independent with activity pursuits and did not attend many group activities per her choice. She also received one to one programming three times a week, which could include visiting, pet therapy, lotion, walks, or outdoors. Care plan Interventions included a phone to be placed on her bed per her preference, assistance with turning the channel with the television remote and ensuring that her remote was within reach, assistance escont a construction and reviewed to her could include visiting, pet therapy, 252 preference. The care plan also indicated R32 was to receive a newspaper delivered to her room daily. R32's tikes included reading the newspaper, watching television, itschuigt to there week a newspaper delivered to her room daily. R32's tikes included reading the newspaper, watching television, itschuigt to there week a nowspaper delivered to her room daily. R32's tikes included reading the newspaper, watching television, itschuigt to the readio, music, talking on the telephone and visiting with family	NAME OF I	PROVIDER OR SUPPLIER						
KK all model reach conflored set of the second set of th	STERLIN	IG PARK HEALTH CA	RE CENTER			WAITE PARK, MN 56387		
 (R32) reviewed for activities, was provided with activities to meet their individual preferences in accordance with the comprehensive resident assessment, including activities which took place outside of the resident from. Findings include: R32's quarterly minimum data set (MDS) dated 9/26/13, identified she had a moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs) except eating. R32's activity care plan dated 10/3/13, indicated she was independent with activity pursuits and did not attend many group activities per her choice. She also received one to one programming three times a week, which could include visiting, pet therapy, lotion, walks, or outdoors. Care plan interventions included a phone to be placed on her bed per her preference, assistance with turning that her remote was within reach, assistence/ escort to activity functions, activities which did not involve overy demanding tasks such as current events and organizing papers as per R32's preference. The care plan also indicated R32 was to receive a newspaper delivered to her room daily, R32's likes included reading the newspaper, watching the telephone and Visiting with family and others. During observation on 12/17/13, at11:45 a.m. R32 was observed sitting in her room in her wheelchair. The television was on, but there was no action her resond. At the stime was no action her solar was playing with a tissue. There was no action her resond. At the stime was no action her resond. 	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
RM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6U1311 Facility ID: 00643 If continuation sheet Page 46 of 120		(R32) reviewed for activities to meet th accordance with the assessment, includ outside of the resid Findings include: R32's quarterly min 9/26/13, identified s impairment and req with activities of dai R32's activity care is she was independed did not attend many choice. She also re programming three include visiting, pet outdoors. Care pla phone to be placed preference, assista with the television r remote was within r activity functions, ac overly demanding ta and organizing pap The care plan also a newspaper delive likes included readi television, listening the telephone and v During observation R32 was observed wheelchair. The tel no volume on, and tissue. There was n time of this observa	activities, was provided with eir individual preferences in a comprehensive resident ing activities which took place ent room. imum data set (MDS) dated he had a moderate cognitive uired extensive assistance ly living (ADLs) except eating. olan dated 10/3/13, indicated nt with activity pursuits and y group activities per her eceived one to one times a week, which could therapy, lotion, walks, or n interventions included a on her bed per her nce with turning the channel emote and ensuring that her each, assistance/ escort to ctivities which did not involve asks such as current events ers as per R32's preference. indicated R32 was to receive red to her room daily. R32's ng the newspaper, watching to the radio, music, talking on visiting with family and others. on 12/17/13, at 11:45 a.m. sitting in her room in her evision was on, but there was the resident was playing with a o radio in her room. At the tion there was organ music			 Resident # 32 had community.life plan reviewed and updated of 12/20/13 with current resident preferences. All Residents activity preferences will be assessed on admission annually and with signic change in condition an reviewed on a quartert basis. The ED/DNS and/or he designee will complete audits per week for on month then weekly for months. The data collected will presented to the QA Committee by the DNS The data collected will reviewed/discussed a quarterly QA meeting this time the QA Com will make the decision/recommendar regarding any follow-t studies. Date of Completion: January 2014 	n, ficant d y er. two e two be S. be t the At mittee ation up 24,	

RM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/10/2014 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G			E SURVEY IPLETED
		245375	B. WING	i	·		12/	20/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			142 NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 248	Continued From pay being played in the	-	F 2	248	8			
	R32 was sitting in h The resident was sl	on 12/18/13, at 10:20 a.m. er wheelchair in her room. eeping on and off with the room. A newspaper was lying 32.						
	stated she liked to li daily news. R32 sta especially dogs. Sh have any activities s she only left her roo liked to listen to the	12/18/13, at 10:25 a.m. R32 isten to the current events and ated she loved animals, the stated the facility did not she could be involved in and im for meals. R32 stated she radio news shows, but she the did not have a radio to			· · ·			
	was observed sitting	on 12/18/13, at 1:15 p.m. R32 g in her wheelchair in her on the television with no						
		on 12/19/13, at 8:50 a.m. R32 ing in her wheelchair, ision was not on.						
	R32 was in her roon	on 12/19/13, at 11:20 a.m. n sitting in her wheelchair sion was on with no volume dio in her room.				•		
	was in her wheelcha hallway with her feel in the dining room al down the hallway fro assistant (NA)-E wa	on 12/19/13, at 3:45 p.m. R32 air, propelling herself down the t. There was a band playing rea. She was about five feet om her room when nursing lked behind R32 and stated, our room." NA-E pushed R32						

ORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

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If continuation sheet Page 47 of 120

DEPART		AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245375	B. WING			-	12/2	20/2013
VAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET /AITE PARK, MN 56387			
<u> </u>		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN	OF CORRECTIO	٧	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULE TO THE APPROP IENCY)	BE RIATE	COMPLETION DATE
F 248	Continued From pa	age 47	F	248				
	back into her room hallway going towa	even though she was in the rds the music.						
	stated R32 usually and when she did s confused. NA-E st	12/19/13, at 3:45 p.m. NA-E did not come out of her room she seemed to get more ated R32 did not come to rred to stay in her room to d read the paper.			·			
	(activity assessmendated 12/24/12, inclusion of the session of the	Enrichment Assessment int completed on admission) licated R32 enjoyed exercise, ikings, and listening to the ment revealed R32 liked to al radio station) on all the time 2 also enjoyed books, 5, flowers and gardening, sing, parties and social events, ors, pets, and sorting things. ity settings were identified as dent room, the facility day room vity room. The activity ary noted, "Bath weekly, I no longer attends or radio and having T.V. ON), newspaper daily and Phone within reach."				•		
	dated 12/12/13, inc and the only currer communion, music on the form indicate would like music." The facility assess	eation/ Wellness Assessment licated all past preferences at preferences were and reminiscing. A summary ed, "Happy hour red wine, ment titled Preferences for and Activities dated 12/12/13,			~			
RM CMS-25	indicated it was "ve	ery important" for R32 to have		Fac	sility ID: 00643	If continuatio	n sheet P	age 48 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING			12/	20/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RECENTER			VAITE PARK, MN 56387		
, (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5). COMPLETION DATE
F 248	books and newspar animals, keep up w to participate in relig The resident indicat important" to listen to with groups of peop activities. Review of R32's red Daily Activity Involve indicated she had "r Facility staff had do leisure" daily, which window, reading, an room. Review of the activit R32 had only three date (12/19/13), and November 2013. Th in R32's room, talkir magazines. On 11/14/13, activity [R32] about music a staff 'I'd like that.' S favorite songs and s On 10/22/13, activity [R32] about listening and stated 'I really li During interview on licensed practical nu usually refused activ sometimes bingo. L sure of R32's specif liked to come out of	bers to read, be around ith the news, get fresh air, and gious services or practices. red it was "somewhat to music she liked, do things le, and do her favorite cord of activities attended, ement Record for 12/13, refused" all activities offered. cumented, "self-directed included looking out her id television in her resident ty progress notes identified activity visits in December to d six activity visits were all noted ng about all the snow and her y visits noted, "Visited with and she smiled and stated to taff talked with [R32] about she stated 'organ.' y visits noted "Visited with g to organ music, she smiled	F	248			

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Facility ID: 00643

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If continuation sheet Page 49 of 120

- ININTED. 01/10/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			Ol	FORM AP MB NO. 09	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:		LTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
245375	B. WING	I		12/20/	2013
NAME OF PROVIDER OR SUPPLIER			S, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER		142 NORTH FIR WAITE PARK,			
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPF DEFICIENCY)	BE CC	(X5) DMPLETIOŇ DATE
 F 248 Continued From page 49 During interview on 12/20/13, at 11:05 a.m. activity (A)-A stated R32 liked to come to social or pizza parties, but it was a "hit or miss" if the resident came to the activity or not. She stated times R32 would come to an activity and then leave half way through. She stated the facility daily news before lunch, and R32 was "usually' invited to come. A-A stated she began working the facility in 5/13 and was still in the process or getting to know resident likes and dislikes. Although R32 had specific likes and dislikes. Although R32 had specific likes and dislikes, at indicated she enjoyed music and visiting with others, the resident did not leave her room to attend activities. An activity policy was requested but not provide 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 documer review, the facility failed to ensure the plan of care was followed for 3 of 5 residents (R32, R4 and R11) who were reviewed for falls and for 1 2 residents (R47) reviewed with pressure ulcers. Findings include: R32's care planned interventions for fall prevention were not followed by staff. 	s at did at f nd ed. F 2 y	of correct not cons interprete agreeme of the fac set forth deficienc prepared executed of state a Without w	paration of the following p etion for this deficiency do titute and should not be ed as an admission nor a ent by the facility of the tru- ets alleged or conclusions in the statement of ies. The plan of correction for this deficiency was solely because provision nd federal law require it. <i>aving the foregoing</i> t, the facility states with	oes in uth s on	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM OMB NO	APPROVED . 0938-0391
	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245375	B. WING _		12	/20/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG PARK HEALTH CA	RECENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
o i civen				PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OPRIATE	DATE
F 282	R32's quarterly Mir 9/26/13, identified to cognitive impairme assistance with act except eating, and bladder. R32's care plan da is at risk for falls re- with behavioral dis decisions, and nee- toileting. Had fall of and pelvic ring frac- due to fall 9/17/13. were "Anti-rollback prevent any falls toileting more than before meals, and repositioning to pro- to TABS alarm pla room close to nurse frequent monitorin product on top of v sliding out of whee- pedals when not be like phone placed morning to ease a her reach when in The current nursind dated 12/17/13, in to lie down when of between meals independently pro- to sit in wheelchail bed table over lead	himum Data Set (MDS) dated the resident had moderate int, required extensive tivities of daily living (ADLs) was frequently incontinent of ated 10/29/13, instructed, "[R32] elated to history of Parkinson's turbance, poor safety ed for assist with ADLs and on 5/1/13 with right hip fracture cture pelvic fracture 9/20/13 " The facility interventions is mechanism to wheelchair to has asked not to be offered upon rise, HS (hour sleep), with staff assisted event falls family is opposed cement for fall notification sing station to facilitate more g for self-transfers non-slip wheelchair cushion to prevent elchair, remove wheelchair being propelled by staff would on bed after bed is made in ccess ensure remote is within		 Resident #32 had care reviewed and intervent updated for falls. Resid #32 has been on freque monitoring to ensure the interventions have bee place. Resident #48 had care previewed and intervent updated for falls. Resid #48 has been on freque monitoring to ensure the interventions have bee place. had care plan reviewed and intervent updated for falls. Resident #11 had care previewed and intervent updated for falls. Resident #11 had care previewed and intervent updated for falls. Resident #11 had care previewed and intervent updated for falls. Resident #47 will have comprehensive skin assessment completed 1/24/14 and care plan we be updated accordingly. All residents with falls in past 6 months were reassessed with abater plan and care plan updated accordingly. Residents with current pressure ulcers will be reassessed and care plupdated accordingly by 1/24/14. Staff educated during abatement plan on how identify residents care planned interventions on care sheets, as well as new fall interventions with communicated. 	ions lent ent iat n in olan ions ent ent at n in ewed lan ons by vill n nent ated an to n the now	

ORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 51 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ſ		APPROVED 0938-0391
				TIDI	E CONSTRUCTION		ESURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		245375	B. WING			12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER		-	42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
F 282	R32 was in her roo light was on the floot table next to her an R32 was leaning ov off the floor and the each time she lean During interview on stated R32 used he stated if staff place her with all of her s self-propel around NA-B verified R32's according to the pla table in front of her During observation R32 was sitting in h The bedside table w with the telephone wrapped around th were about four to were not within her wheelchair cushion was observed on th During interview on director of nursing have had her bedsi with the telephone, and call light within During observation was observed sittin room. The call ligh her, about two feet was on the bed and newspaper. The ref	m in her wheelchair. The call or behind her, with the bedside of the phone on the nightstand. ver trying to pick up Kleenex wheelchair rolled back slightly ed forward. 12/17/13, at 11:34 a.m. NA-B er call light "sometimes." She d her bedside table in front of upplies, she generally did not the room in her wheelchair. s room was not set up an of care with the bedside to prevent falls. on 12/18/13, at 10:20 a.m. her wheelchair in her room. was located against the wall, on it and the call light was e grab bar on her bed. Both five feet away from R32 and reach. R32 was seated on a ; however, no anti-slip pad he cushion. 12/18/13, at 10:36 a.m. (DON) verified R32 should de table placed in front of her newspaper, remote control,		282	 The DNS or designee will complete five audits per week for one month. The data collected will be presented to the QA Com by the DNS. The data co will be reviewed/discusse the quarterly QA meeting this time the QA Committ make the decision/recommendation regarding any follow-up st Date of Completion: January 24, 2014 	imittee Ilected d at . At ee will	
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1311		Fac	cility ID: 00643 If continuation	on sheet Pa	age 52 of 120

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If continuation sheet Page 52 of 120

	IMENT OF HEALTH						•	FORM	: 01/10/ APPRO . 0938-0	VED
STATEMENT AND PLAN C	JPPLIER/CLIA ON NUMBER:	1				(X3) DAT	E SURVE			
		245	375	B. WING				12	20/201	3
NAME OF I	PROVIDER OR SUPPLIER			1		STREET ADDRESS, CITY, ST				
STERLIN	IG PARK HEALTH CA	RE CENTER			-	42 NORTH FIRST STREE WAITE PARK, MN 5638				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	<	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD ID TO THE APPROPHICIENCY)	BE	(X5) COMPLE DATE	TION
F 282	Continued From par wheelchair cushion During interview on above observation of nurse and confirmer control, newspaper, R32 reach. She stat under R32's wheelo visible. She was un staff that R32 was to of the wheelchair cu- sliding out of her whe During observation of was in her room sitt sleeping. The beds wheelchair with the light was wrapped a which out of R32 rea During observation of R32 was in her room sleeping. The beds wheelchair with the light was pinned to t to four feet away fro Although R32 had m were identified on th these falls, the care prevent further falls.	as directed by 12/18/13, at 1:2 of R32 was veri d R32 call light, and phone sho ted the anti-slip hair cushion bu aware the care o have an anti-s shion to prever belchair. on 12/19/13, at ing in her whee ide table was bo remote control round the grab ach. on 12/19/13, at n sitting in her v de table was bo remote control round the grab ach.	20 p.m. the fied the MDS remote build be with in mat was it was not plan directed slip mat on top ht her from 8:50 a.m. R32 Ichair, ehind her on it. The call bar on the bed 11:20 a.m. vheelchair, ehind her on it. The call imately three	F 2	82					
	R48's care planned i prevention had not b R48's admission MD diagnoses of hip frac	een followed by S dated 10/18/ cture, hypertens	y staff. 13, included sion (elevated							
	blood pressure), and indicated R48 had se 7(02-99) Previous Versions C	evere cognitive			Faci	ility ID: 00643	If continuetion	obcot D		100
200							If continuation	SHEELPE	iye 00 01	120

		AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245375	B. WING				12/	20/2013
NAME OF I	PROVIDER OR SUPPLIER	· · ·			STREET ADDRESS, CITY, STATE, ZIF	PCODE		
STERLIN	IG PARK HEALTH CA	RE CENTER		-	WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD 1E APPROPF	BE	(X5) COMPLETION DATE
F 282	required extensive had fallen prior to a Assessment (CAA) was at risk for falls cognitive deficit, can these risks. R48's care plan dat is at risk for falls r/t cognitive loss with i incont [incontinent], analgesia use, and directed staff to ensi- her bed in low posit The care plan also determine the causa An undated NA Car to leave walker in p checks, and keep h transfer height. R48's Resident Inci 12:00 a.m. indicated get out of bed, her to position, not at trans care plan. R48's Resident Inci 1:30 a.m. indicated out of bed. The Inc her walker had not to the care plan. Staff walker within reach. R48's Resident Inci 1:30 a.m. indicated out of bed. The Inc her walker had not to the care plan. Staff walker within reach.	assistance for all ADLs, and dmission. The fall Care Area dated 10/16/13, indicated R48 related to poor balance and re planning would occur due to ed, 10/24/13, included, "[R48] [related to] history of, mpaired decision making, new to environment, daily osteoporosis." The care plan sure her call light was in reach, ion, and needs anticipated. directed staff to attempt to e of any falls. e Plan for R48, directed staff lace, perform 15 minute er bed at an appropriate dent Report dated 11/2/13, at d R48 had fallen while trying to bed had been in the lowest sfer height as directed by the dent Report dated 11/13/13, at R48 had fallen trying to get ident Investigation indicated been in reach as directed by were re-educated on leaving	F 2	:82				
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1311		Fac	cility ID: 00643	continuation	sheet Pa	I ige 54 of 120

		AND HUMAN SERVICES				0		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION			E SURVEY PLETED
		245375	B. WING				12/2	20/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			142 NORTH FIRST STREET WAITE PARK, MN 56387			
						CORRECTION	1	(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE ·	(X5) COMPLETION DATE
F 282	Continued From pa	-		282		•		
	not leaving R48 una impulsive behavior.	attended on the toilet due to						
	DON verified the ca followed when R48	on 12/19/13, at 2:50 p.m. the are plan had not been being had fallen on 11/2/13 and						
		I further stated it was the leave cognitively impaired he bathroom.						
	licensed practical n tended to forget to a	on 12/19/13, at 4:47 p.m. urse (LPN)-A stated R48 activate her call light on and self once or twice a day, the bathroom.						
	stated R48 attempte twice a week. R48 bathroom. NA-L did	on 12/19/13, at 4:49 p.m. NA-L ed to transfer herself once or was not to be left alone in the d not know what position posed to be in, or where her ed to be located.						
	5:00 p.m. R48 state bathroom. She was time or place. R48	and interview on 12/19/13, at ad the "girls," help her to the s otherwise not oriented to was in bed, with the bed in a r walker across the room, by not by her bed.						
	stated R48 was not alone, her bed was NA-K added that the having R48 sit on th her feet touched the Nursing Assistant C walker was to be ne acknowledged the w	valker was currently across		For		If continuetion	shoet De	
URIVI UNIS-256	67(02-99) Previous Versions	Obsolete Event ID:6U131	1	гас	cility ID: 00643	n continuation	sneet Pa	ge 55 of 120

PRINTED: 01/10/2014

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER 245375 B. WING 12/20/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/20/201 STERLING PARK HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387 WAITE PARK, MN 56387 (K4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (K5) COMPLEX			AND HUMAN SERVICES	·			FOR	D: 01/10/2014 MAPPROVED O. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STERLING PARK HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (CA) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRICEDED (EACH DEFICIENCY) PROVIDERY AND OF CORRECTION (EACH DEFICIENCY) PROVIDERY AND OF CORRECTION (CODE COMPL (EACH DEFICIENCY) PROVIDERY AND OF CORRECTION (EACH DEFICIENCY) COMPL (EACH DEFICIENCY) PROVIDERY AND OF CORRECTION (CODE COMPL (EACH DEFICIENCY) CO	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) D	ATE SURVEY
142 NORTH FIRST STREET WATE PARK, MN STATEMENT OF DEFICIENCIES FAC 142 NORTH FIRST STREET WATE PARK, MN SG3Z PAULD FAC SUMMANY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000841 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SHOULD AND AND ADD ATE ATT'S CORRECTION AND ADD ACTION THE APPROPRIATE DEFICIENCY) 000841 (EACH CORRECTION DEFICIENCY) 000841 (EACH CORRECTION SHOULD ACTION DEFICIENCY) (EACH CORRECTION ACTION ADD THE ADD ADD ADD ADD ADD ADD ADD ADD ADD ATT'S ADD ADD ADD ADD ADD ADD ADD ATT'S ADD ADD AD			245375	B. WING	;		1	2/20/2013
STEELING PARK HEALTH CARE CENTER WAITE PARK, MN 56387 (x) D PREFIX TAQ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEFRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENTIFY LAND OF CORRECTION CONSCIONT (EACH DEFICIENCY MUST BEFRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENTIFY TAG PROVIDENTIFY LAND OF CORRECTION CONSCIONT (EACH DEFICIENCY MUST BEFRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENTIFY TAG F 282 Continued From page 55 the room. F 282 R11's current care plan dated 10/13/13, indicated she had diagnosis of osteoporosis. The care plan also indicated she was at moderate risk for falls related to being unaware of safety needs, short term memory loss, psychotropic med use, gait and balance problems and balded rugency with incontinence. The care plan indicated she needed assist of one with toileting and transfers, had a low bed with fail mat pressure-sensor pad on her bed, TABS alarm in chair and staff were to review information on past fails and attempt to determine the cause of fails if possible and educate. The care plan also indicated she had urge incontinence of bladder, was able to maintain bladder continence during waking hours with holieting every three hours and as needed if she showed increased attempts to self-transfer. R1's nursing assistant care plan indicated she had a sensor pad in her bed, low bed, flor mat next to her bed, nonsilic curbes on her wheelchair, ant alarm on wheelchair, and toileting every three hours during the day and two hours at night, returning in ten minutes to check if she needed to toilet again. R1's current annual MDS dated 10/16/13, indicated she was moderately cognitively intact, needed extensive assistance with transfers, embulation, and bed mobil	NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CO	ODE	/
PEEDIX TAG reach consecutive actions should be reductive on the security of the	STERLIN	IG PARK HEALTH CA	RE CENTER		ł			
the room. R11's care planned interventions for fall prevention had not been followed by staff. R11's current care plan dated 10/13/13, indicated she had diagnosis of osteoporosis. The care plan also indicated she was at moderate risk for falls related to being unaware of safety needs, short term memory loss, psychotropic med use, gait and balance problems and bladder urgency with incontinence. The care plan indicated she needed assist of one with toileting and transfers, had a low bed with fall mat, pressure-sensor pad on her bed, TABS alarm in chair and staff were to review information on past falls and attempt to determine the cause of falls if possible and educate. The care plan also indicated she had urge incontinence of bladder, was able to maintain bladder continence during waking hours with toileting every three hours and as needed if she showed increased attempts to self-transfer. R11's nursing assistant care plan indicated she had a sensor pad in her bed, floor mat next to her bed, nonslip cushion in her wheelchair, anti-rollback brakes on her wheelchair, anti-rollback brakes on her wheelchair, and alarm on wheelchair, and toileting every three hours during the day and two hours at night, returning in ten minutes to check if she needed to toilet again. R11's current annual MDS dated 10/16/13, indicated she was moderately cognitively intact, needed extensive assistance with transfers, ambulation, and bed mobility. The MDS also	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
prevention had not been followed by staff. R11's current care plan dated 10/13/13, indicated she had diagnosis of osteoporosis. The care plan also indicated she was at moderate risk for falls related to being unaware of safety needs, short term memory loss, psychotropic med use, gait and balance problems and bladder urgency with incontinence. The care plan indicated she needed assist of one with toileiting and transfers, had a low bed with fall mat, pressure-sensor pad on her bed, TABS alarm in chair and staff were to review information on past falls and attempt to determine the cause of falls if possible and educate. The care plan also indicated she had urge incontinence of bladder, was able to maintain bladder continence during waking hours with toileiting every three hours and as needed if she showed increased attempts to self-transfer. R11's nursing assistant care plan indicated she had a sensor pad in her bed, low bed, floor mat next to her bed, nonslip cushion in her wheelchair, an alarm on wheelchair, and toileiting every three hours during the day and two hours at night, returning in ten minutes to check if she needed to toilet again. R11's current annual MDS dated 10/16/13, indicated she was moderately cognitively intact, needed extensive assistance with transfers, ambulation, and bed mobility. The MDS also	F 282	-	ge 55	F	282			
she had diagnosis of osteoporosis. The care plan also indicated she was at moderate risk for falls related to being unaware of safety needs, short term memory loss, psychotropic med use, gait and balance problems and bladder urgency with incontinence. The care plan indicated she needed assist of one with toileting and transfers, had a low bed with fall mat, pressure-sensor pad on her bed, TABS alarm in chair and staff were to review information on past falls and attempt to determine the cause of falls if possible and educate. The care plan also indicated she had urge incontinence of bladder, was able to maintain bladder continence during waking hours with toileting every three hours and as needed if she showed increased attempts to self-transfer. R11's nursing assistant care plan indicated she had a sensor pad in her bed, low bed, floor mat next to her bed, nonslip cushion in her wheelchair, an alarm on wheelchair, and toileting every three hours during the day and two hours at night, returning in ten minutes to check if she needed to toilet again. R11's current annual MDS dated 10/16/13, indicated she was moderately cognitively intact, needed extensive assistance with transfers, ambulation, and bed mobility. The MDS also								
assessment of 10/9/13, and was frequently incontinent of bladder. R11's admission CAA dated 10/10/13, indicated R11 had a potential for falls had fallen 30 days prior to admit, was on a		she had diagnosis of plan also indicated a falls related to being short term memory gait and balance pro- with incontinence. needed assist of on- had a low bed with f on her bed, TABS a review information of determine the cause educate. The care p urge incontinence of maintain bladder con- with toileting every t she showed increas R11's nursing assist had a sensor pad in next to her bed, non- wheelchair, anti-rollt wheelchair, an alarm every three hours du night, returning in te needed to toilet agai R11's current annua indicated she was m needed extensive as ambulation, and bed indicated R11 had no assessment of 10/9/ incontinent of bladded	of osteoporosis. The care she was at moderate risk for g unaware of safety needs, loss, psychotropic med use, oblems and bladder urgency The care plan indicated she e with toileting and transfers, fall mat, pressure-sensor pad larm in chair and staff were to on past falls and attempt to e of falls if possible and plan also indicated she had f bladder, was able to ntinence during waking hours hree hours and as needed if red attempts to self-transfer. cant care plan indicated she her bed, low bed, floor mat islip cushion in her back brakes on her n on wheelchair, and toileting uring the day and two hours at n minutes to check if she in. I MDS dated 10/16/13, noderately cognitively intact, ssistance with transfers, I mobility. The MDS also o falls since the prior '13, and was frequently er. R11's admission CAA cated R11 had a potential for					

Facility ID: 00643

If continuation sheet Page 56 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			O	FORM A	APPROVED 0938-0391
	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245375	B. WING			12/2	0/2013
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		DE CENTER			142 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA				WAITE PARK, MN 56387	J	(X5)
(X4) ID PREFIX TAG	(EACH DEELCIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 282	The CAA also indic disorientated with a in addition to intend CAA also indicated monitoring health s toileting with repro- declined the offer, with pressure sense room next to nurse identify looking at re-evaluating her to R11's Resident indi- following falls relati- care and resident Fall on 11/4/13, at floor in her room, I was found ten min- incident report ind- intervention was to resident unattende Fall on 9/30/13, at floor mat next to b- indicated resident a.m. and during in she checked her p back and check to toilet soon after. If plan of care and o should be checke hours at night, if s void, they were to minutes later and on night shift also Fall on 8/22/13, at mat sitting next to indicated staff rep	equently incontinent of urine. ated R11 was alert and a recent history of frequent falls ional position changes. The interventions including status for changes, regular ach ten minutes later if she pain management, low bed for, alarm in wheelchair, and is station. The CAA did not extrinsic factors or oileting plan related to falls. ident reports revealed the ed to staff not following plan of toileting: 5:00 a.m. resident found on had been on commode and utes later on the floor. The facted the immediate or re-educate staff not to leave ed on the commode. 4:45 a.m. resident found on ed. The fall investigation had last been toileted at 2:00 terview with nursing assistant oad at 4:00 a.m. but did not go o see if she needed to use the Educated nursing assistant to are sheets that state resident d and offered toileting every two he stated she did not need to go back in approximately ten ask again. Registered nurse		282			
ORM CMS-	 2567(02-99) Previous Versio		11		Facility ID: 00643 If continuat	ion sheet I	Page 57 of 120

	MENT OF HEALTH	AND HUMAN S	ERVICES ERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUF IDENTIFICATION	PLIER/CLIA	· ·		E CONSTRUCTION			E SURVEY PLETED
		2453	75	B. WING				12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER				42 NORTH FIRST STREET /AITE PARK, MN 56387			
	SI IMMARY ST	ATEMENT OF DEFICIE	NCIES	ID		PROVIDER'S PLAN	OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED DEFIC			COMPLETION DATE
F 282	Continued From parts she needed to use necessarily get R1 ⁻¹ or reoffer toileting. staff would go in ar hours, if she was s her up and ask her check her brief. If return in ten minute staff were to ask her During interview or verified that the fall following R11's car	the toilet but they 1 up if she said no R11 was care pland offer to toilet h leeping staff were if she needed to she was dry staff es and if she was er again. 12/19/13, at 10: s all occurred du	o to toileting anned that er every two e still to wake toilet and were to still awake, 30a.m. DON e to staff not	F 2	282				
	The facility failed to repositioning for Racare.	o offer or impleme 47 as directed by	ent timely the plan of						-
	R47's care plan, la identified the press various intervention be repositioned or Tolerance Test- a to profusion] every ho presence of press compromised at 2 decline this while e Group-A NA works staff to turn and rep and PRN (as need	ure ulcers, and ir off-loaded per TT est used to meas our recommended ire ulcers, howev hours. Respect [I xplaining risk/ber heet, dated 12/18 position [R47] eve ed).	ncluded [R47 was to] T [Tissue ure tissue d d/t [due to] er, [R47] R47's] right to nefits." The B/13, directed ery two hours						
RM CMS-25	During observation to 9:42 a.m., (2 hou lying on his back in bed slightly elevate observation R47 w staff. At 7:59 a.m., (LPN)-B entered th medications to R47	urs and 52 minute his bed with the d. During the co as not offered rep licensed practica e room and admi via a feeding tul	es), R47 was head of the nstant positioning by al nurse nistered		Fac	ility ID: 00643	If continuatio	n sheet Pa	age 58 of 120

		AND HUMAN SERVICES				PRINTED: 01/10/ FORM APPRO OMB NO. 0938-0		
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION			TE SURVEY APLETED
		245375	B. WING			•	12	/20/2013
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STAT	E, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET /AITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 282	a.m., LPN-B comple administration, and not offer or repositio room during the me At 9:41 a.m. NA-D e odor and requested	ge 58 eted R47's medication exited the room. LPN-B did on R47 while in the resident dication administration. entered R47's room, noted an d assistance. At 9:42 a.m., bom and assisted NA-D with	F 2	82				
	During an interview NA-D could not reca repositioned, but ve two hours. In anoth NA-D verified R47 n every two hours per							
	LPN-C stated R47 p and the resident cur his upper back. LPN two hour repositionin care. LPN-C stated develop pressure uk "dependence, immo LPN-C also acknown repositioned after the around 8:00 a.m. During an interview of the DON stated it wa were repositioned tin care plan be followed ulcers." DON agree	bility," and other risk factors.						

DRM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00643

If continuation sheet Page 59 of 120

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	IMENT OF HEALTH						FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SL IDENTIFICATIO	IPPLIER/CLIA			E CONSTRUCTION		E SURVEY IPLETED
	÷	245	375	B. WING	•		12/	20/2013
NAME OF I	PROVIDER OR SUPPLIER	· ·				TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RE CENTER			-	VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE C HIGHEST WELL B	EING		F 3	309	F 309		
	Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care.	ary care and sen nest practicable psocial well-bein	rvices to attain physical, g, in			The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the t of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct	loes an ruth is	
	This REQUIREMEN by: Based on interview facility failed to asse of 1 residents (R48) pressures and char after a fall. In additi and monitor 1 of 4 r nutrition, for sympto failure.	y and document ess and consiste) that had an ele nge in neurologi ion, the facility fa residents (R50)	review the enly monitor 1 evated blood cal symptoms ailed to assess reviewed for			prepared for this deficiency was executed solely because provision of state and federal law require in Without waiving the foregoing statement, the facility states with respect to:	ons	
	Findings include:							
	R48 had elevated b injuries, and abnorn The facility failed to symptoms, or notify	nal neurological consistently mo	assessments.					
	R48's admission Mi 10/18/13, included of hypertension (eleva dementia. The MDS cognitive impairmen assistance for all ac and had fallen prior	liagnoses of hip ted blood press S indicated R48 it, required exte tivities of daily li	fracture, ure), and had severe nsive					
	R48's Fall Risk Asse risk factors for falls,							
RM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6U1311		Facil	lity ID: 00643 If continuation	sheet Pa	ge 60 of 120

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	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245375	B. WING			12/:	20/2013
	PROVIDER OR SUPPLIER		I	14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	 was included of 166 an orthostatic blood taken while lying, si determine if there w with position chang antihypertensive m feeling dizzy or ligh cause a fall). R48's care plan dat hypertension (high and directed staff to to medical practition [signs or symptoms Headache, visual p disorientation, letha irritability, seizure a (Dyspnea)." R48's physician ord three medications to Accupril 20 mg (mil daily, and Toprol XI R48's Resident Inclindicated she had fa Blood pressures at documented as: ly hg (mercury) and s pressure (183/76) w record under Progre 5:07 a.m. R48's blood elevated more than was no evidence in indicate her physici elevated blood pressures 	edication, a blood pressure 5/67; however, did not include I pressure (blood pressure tting, then standing used to /as a drop in blood pressure es; a potential side effect of edication, which can lead to theaded and could potentially red 10/24/13, included blood pressure) as a focus, b, "Observe/document/report ner PRN [as needed] and s/sx of malignant hypertension: roblems, confusion, rgy, nausea and vomiting, ctivity, difficulty breathing lers dated 12/2/13, included o control hypertension: ligrams) daily; Cozaar 60 mg	F	309	 Resident #50 weight continues to be monitored daily per physician orders. Weight has been stable greater than 30 days. RD does have resident on high risk list and will continue to follow resident's weight changes. Ongoing communication with MD wi be completed if change noted per change in condition guidelines. Resident #48 had blood pressure monitoring every hours from 12/20/13 through 12/26/13 with no significant elevated blood pressures noted. Progress notes will be reviewed by DNS or designee 5 times per week for 4 weeks. Nursing staff education will be completed by January 24, 2014 on policy and 30 	11 	

DRM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: 6U1311

Facility ID: 00643

If continuation sheet Page 61 of 120

		& MEDICAID SERVICES	(Y2) MU				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		245375	B. WING			12/2	20/2013
AME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TERLIN	IG PARK HEALTH CA	RE CENTER		• •	2 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	no further orthostati documented. R48's Resident Inci 12:00 a.m. indicated with a blood pressu of the fall. R48 hit H Neurological Assess initiated, which inclu- checks during the 2 addition, the Neurol Sheet indicated R44 pain on 11/2/13, at a.m. The final bloo at 12:30 a.m. was 1 blood pressure (18) Signs in the electro 10:29 a.m. R48's b elevated three days evidence in R48's m orthostatic blood pre- the blood pressures monitored and repo R48's Resident Inci 12:30 a.m. indicated During this fall, R48 three centimeter (cr (large collection of b back of her head. F time was 181/84 sit Neurological Assess initiated, dated 11/8 checks were compli- hours. At 4:00 a.m. elevated at 199/75. Assessment Flow S	dent Report dated 11/2/13, at d a second fall had occurred, re of 215/81 noted at the time her head during the fall and a sment Flow Sheet was uded frequent blood pressure 4 hours following the fall. In ogical Assessment Flow 8 had complained of head 12:05 a.m., and again at 3:50 d pressure check on 11/3/13, 76/70. The next documented 7/78) was located under Vital nic record dated 11/5/13, at lood pressure had remained after the fall. There was no nedical record that an essure had been taken, or that s and head pain had been rted to the physician. dent Report dated 11/8/13, at d R48 had fallen a third time. hit her head and sustained a n) by four cm hematoma blood under the skin) to the R48's blood pressure at that ting and 199/103 lying. A sment Flow Sheet was /13, and blood pressure eted every four hours for 24 her blood pressure remained	F	309	procedure of change in condition notification 5. . The DNS and/or her designee will conduct a weekly on any residents a change in condition at assure these conditions identified on the resider plan. 5. All incident reports will be revier by DNS, ED and/or designee post incident for discrepancies in vital s 6. The data collected will be reviewed/discussed at the monthly meeting. At this time the QA committee will make the decision/recommendation regardin any follow-up studies and required audits Completion date: January 24, 20	udits s with nd are nt care wed t signs y QA	

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Continue Procession Continue Procession <thcontinue procession<="" th=""> Continue Procession</thcontinue>			AND HUMAN SERVICES					FORMA	01/10/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STREET STREET ADDRESS, CITY, STREET STERLING PARK HEALTH CARE CENTER MATTE PARK, MN 56337 Image: Control of the Co	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA						
STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET STERLING PARK HEALTH CARE CENTER 10 PRETX REGULATION OR LEGISTICS PRETX REGULATION OR LEGISTICS PRETX REGULATION OR LEGISTICS TAG REGULATION OR LEGISTICS TAG REGULATION OR LEGISTICS PRETX REGULATION OR LEGISTICS TAG REGULATION OR LEGISTICS TAG REGULATION OR LEGISTICS PRETX REGULATION OR LEGISTICS TAG REGULATION OR LEGISTICS PRETX REGULATION OR LEGISTICS TAG STANDAL TAG TAG TAG S			245375	B. WING)			12/2	0/2013
STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 66387 OPALING PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EXCH OFCIENCY VISUSTE E FEEDED BY FULL (EXCH OFCIENCY) PROVIDER'S FLAN OF CORRECTION (EXCH OFCIENCY) OWN (EXCH OFCIENCY) F 309 Continued From page 62 sluggish (a potential sign of brain trauma) and remained sluggish until 11/9/13, at 12:00 a.m. when the assessment stopped. The final blood pressure was 167/72, noted on 11/9/13, at 12:00 a.m. noted R48 complained of a headache and had vonted fafte breakfast. F48's relative was contacted and, "Explained that the only way to know if she has any bleeding present would be with a CT scan. Family does not want to be aggressive in residents care and at this time [family member] requests that we just monitor" A1:206 p.m., another progress note indicated R48's Resident incident Report fall." There was no indicated she had fallen a fourth time, egain hitting her headR48's blood pressure at the time of the fall was 214/80 lying and 168/89 sitting. A Neurological Assessment Flow Sheet had been initiated for the 24 hours. There was no evidence in the medical record that the physican had been antified of the elevated blood pressures, or the sluggish with serve as no evidence in the medical record that the physican had been antified of the elevated blood pressures, or the sluggish publis. Neurological Assessment plotod pressures, or the sluggish publis. R48's medication administration record pressures, or the sluggish publis. B48's medication administration record (MAR) starting 11/20/13, incluided, "B/P and P [blood p	NAME OF I	PROVIDER OR SUPPLIER					, ZIP CODE		
Continued From page 62 stuggish (a potential sign of brain frauma) and remained sluggish until 11/9/13, at 12:00 a.m. when the assessment stopped. The final blood pressure was 167/72, noted on 11/9/13, at 12:00 a.m. noted R48 complained of a headcache and had vomited after brakfast. R46's relative was contacted and, "Explained that the only way to know if she has any bleeding present would be with a CT scan. Family does not want to be aggressive in residents care and at this time [family member] requests that we just monitor" At 2:05 p.m., another progress note indicated R46's, "Pupils are sluggish with reaction, but nurse had noted this prior to fail." There was no indication in R48's medical record to indicate her physician had been contacted about the elevated blood pressures, pupils becoming sluggish, or the injury to her head. R46's Resident incident Report dated 11/13/13, at 1:30 a.m. indicated she had failen a fourth time, again hitting her head. R48's blood pressure at the time of the fail was 21/480 (brigg and f68/69 sitting. A Neurological Assessment FIOw Sheet had been nititated of the 24 hours following the fail, with blood pressure readings between 11/4/55-166/98. R48's pupils were recorded as sluggish throughout the 24 hours following the fail, with blood pressure readings between 11/4/55-166/98. R48's pupils. R48's medication administration record (MAR) starting 11/20/13, included, "B/P and P [blood pressures, or the sluggish pupils.	STERLIN	IG PARK HEALTH CA	RE CENTER		1 .				
 sluggish (a potential sign of brain trauma) and remained sluggish until 11/9/13, at 12:00 a.m. when the assessment stopped. The final blood pressure was 167/72, noted on 11/9/13, at 12:00 a.m. A progress note dated 11/8/13, at 11:10 a.m., noted R48 complained of a headache and had vomited after breakfast. R45's relative was contacted and, "Explained that the only way to know if she has any bleeding present would be with a CT scan. Family does not want to be aggressive in residents care and at this time [family member] requests that we just monitor" At 2:05 p.m., another progress note indicated R48's. "Pupile are sluggish with reaction, but nurse had noted this prior to fall." There was no indication in R48's medical record to indicate her physician had been contacted abut the elevated blood pressures, pupils becoming sluggish, or the injury to her head. R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. indicated of the 24 hours. There was no evidence in the fall was 214/80 lying and 168/89 sitting. A Neurological Assessment Flow Sheet had been initiated for the 24 hours. There was no evidence in the medical for the 24 hours. There was no evidence in the medical for the 24 hours. There was no evidence in the medical for the 24 hours. There was no evidence in the medical for the 24 hours. There was no evidence in the medical for the 24 hours. There was no evidence in the medical record that the physician had been notified for the 24 hours. There was no evidence in the medical record that the physician had been notified of the elevated blood pressures, or the sluggish pupils. R48's medication administration record (MAR) starting 11/22/13, included, "B/P and P [blood pressures, or the sluggish pupils. R48's medication administration record (MAR) starting large particities (MAR) starting 11/22/13, included, TB/P and P [blood pressure and pupils] q [every day] x 1 week, update [nurse practitioner (NP)] PRN [as 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD O THE APPROPF	BE	COMPLETION
noted R48 complained of a headache and had vornited after breakfast. R48's relative was contacted and, "Explained that the only way to know if she has any bleeding present would be with a CT scan. Family does not want to be aggressive in residents care and at this time [family member] requests that we just monitor" At 2:05 p.m., another progress note indicated R48's, "Puplis are sluggish with reaction, but nurse had noted this prior to fall." There was no indication in R48's medical record to indicate her physician had been contacted about the elevated blood pressures, pupils becoming sluggish, or the injury to her head. R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. indicated she had fallen a fourth time, again hitting her head. R48's blood pressure at the time of the fall was 214/80 lying and 168/89 sitting. A Neurological Assessment Flow Sheet had been notified for the 24 hours following the fall, with blood pressure readings between 114/55-168/89. R48's pupils were recorded as sluggish throughout the 24 hours. There was no evidence in the medical record 10MRR) starting 11/20/13, included, "B/P and P [blood pressures, or the sluggish pupils. R48's medication administration record (MAR) starting 11/20/13, included, "B/P and P [blood pressure and pulse] qd [every day] x 1 week, update [nurse practitioner (NP)] PRN [as	F 309	sluggish (a potentia remained sluggish when the assessme pressure was 167/7	al sign of brain trauma) and until 11/9/13, at 12:00 a.m. ent stopped. The final blood	F	309				
 1:30 a.m. indicated she had fallen a fourth time, again hitting her head. R48's blood pressure at the time of the fall was 214/80 lying and 168/89 sitting. A Neurological Assessment Flow Sheet had been initiated for the 24 hours following the fall, with blood pressure readings between 114/55-168/89. R48's pupils were recorded as sluggish throughout the 24 hours. There was no evidence in the medical record that the physician had been notified of the elevated blood pressures, or the sluggish pupils. R48's medication administration record (MAR) starting 11/20/13, included, "B/P and P [blood pressure and pulse] qd [every day] x 1 week, update [nurse practitioner (NP)] PRN [as 		noted R48 complain vomited after break contacted and, "Exp know if she has any with a CT scan. Fa aggressive in reside [family member] red At 2:05 p.m., anoth R48's, "Pupils are s nurse had noted thi indication in R48's r physician had been blood pressures, pu	ned of a headache and had fast. R48's relative was plained that the only way to y bleeding present would be amily does not want to be ents care and at this time quests that we just monitor" er progress note indicated sluggish with reaction, but is prior to fall." There was no medical record to indicate her a contacted about the elevated				• • •		
starting 11/20/13, included, "B/P and P [blood pressure and pulse] qd [every day] x 1 week, update [nurse practitioner (NP)] PRN [as		1:30 a.m. indicated again hitting her her the time of the fall w sitting. A Neurologi had been initiated fo fall, with blood press 114/55-168/89. R44 sluggish throughout evidence in the mer had been notified of	she had fallen a fourth time, ad. R48's blood pressure at vas 214/80 lying and 168/89 ical Assessment Flow Sheet or the 24 hours following the sure readings between 8's pupils were recorded as t the 24 hours. There was no dical record that the physician f the elevated blood	,					
RM CMS-2567(02-99) Previous Versions Obsolete Event ID:6U1311 Facility ID: 00643 If continuation sheet Page 63 of 1		starting 11/20/13, in pressure and pulse update [nurse pract	cluded, "B/P and P [blood] qd [every day] x 1 week, itioner (NP)] PRN [as			ility ID: 00643	16 1'1'	abort D	

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		AND HUMAN SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION			E SURVEY PLETED
		245375	B. WING				12/2	20/2013
	PROVIDER OR SUPPLIER	RE CENTER		1.	TREET ADDRESS, CITY, STAT 42 NORTH FIRST STREET VAITE PARK, MN 56387	E, ZIP CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ı ıx	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 309	between 113/61 to evidence the NP or R48's elevated bloc falls on 10/27/13, 1 R48's NP Nursing H 11/22/13, included a noted, "I do not hav review, but I am no problems." The NF Assessment, "Hype of any problems."	od pressures recorded were 183/96. There was no physician had been notified of od pressures at the time of her 1/2/13, 11/8/13, or 11/13/13. Home Rounds report dated a physical exam. The NP re weights or vital signs to t made aware of any P also noted under ertension, but I am not aware		309				
	10:25 p.m. indicate The report noted Re the fall. R48's bloo recorded as 210/83 Assessment Flow S pressures recorded over the 24 hours for were recorded as e A Centracare Clinic describing the fall, f pressure reading of evidence the physic 210/83 and 200/83 or sluggish pupils. orthostatic blood pr though R48 had a f blood pressure.	ident Report dated 11/24/13, a d R48 had fallen a fifth time. 48 "bumped" her head during d pressure at that time was s sitting. A Neurological Sheet was initiated, with blood I between 113/61 and 200/83 ollowing her fall. R48's pupils ither non-reactive or sluggish. Fax was sent to the physician out noted only a blood f 161/66. There was no cian had been notified of the readings, or the non-reactive There was no monitoring of essures during this time, even history of an orthostatic drop in						
	dated 12/11/13, incl November 8, 2013, complication]; also physical exam the r reasons, her blood	e Rounds by the physician uded, "She had a minor fall on without sequelae [without on October 28, 2013. Under note included, "For technical pressures and weights are not Obsolete Event ID:6U131		Fac	; 	If continuation	sheet Bo	
INN CINS-25	67(02-99) Previous Versions	Cusciele Event 10, 60 131	•	rac	ancy 10. 00040	n continuation	i sneet Pa	age 64 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	D: 01/10/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION		TE SURVEY MPLETED
		245375	B. WING				2/20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA		
STERLIN	IG PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 309	available." There w was informed of the 11/8/13, 11/13/13 a symptoms of vomiti neurological assess indication the physic elevated blood press falls which occurred 11/13, and 11/24/13 When interviewed of director of nursing (had continued moni- hypertension, ortho- declining neurologic physician should ha	vas no evidence the physician head injury sustained on nd 11/24/13 with the ng, head pain, and abnormal sments. Also, there was no cian was informed of the ssures following each of the d on 10/27, 11/2, 11/8/13,		309		, , , ,	
-	Even though R48 h which time her bloo elevated, she had a pressure between h repeated head injur symptoms (change facility failed to notif monitoring symptom An undated facility p When to Report to t /NP/PA (physician's report any systolic (pressures over 210 over 115 immediate 90 the next day. Th need to contact the sustained a contusi fall with no other co	colicy for Change in Condition, he MD (medical doctor) assistant) directed staff to heart contraction) blood , diastolic (heart relaxation) ly, and diastolic routinely over he form also indicated the physician if the resident on associated with a recent mplications, and to send the					
OBM CMS-25	67(02-99) Previous Versions	rgency room immediately Obsolete Event ID:6U131	1	Fac	sility ID: 00643	If continuation sheet	Page 65 of 120

	MENT OF HEALTH	AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DAT CO№	E SURVEY IPLETED
		245375	B. WING		·	12/	20/2013
	PROVIDER OR SUPPLIER	RE CENTER		[·] 14	REET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa following a fall with	a head injury.	F	309			
	R50 had weight ga the facility failed to failure.	in, edema and dyspnea which monitor for congestive heart					
s c f f v i i	R50's admission MDS dated 11/22/13, indicated she had mild cognitive impairment, no or unknown weight loss or weight gain, and was not on a diuretic (medication to reduce fluid). R50's hospital History and Physical dated 11/7/13, indicated diagnoses of hypertension, atrial fibrillation, and resolving congestive heart failure. The History and Physical revealed R50 was hospitalized secondary to recurrent falls, increasing weakness and confusion. It also indicated her weight was 105 pounds (lbs) on						
					•		
	admission to the ho 11/10/13. R50's ho 11/11/13, indicated milligrams (mg) and discharge orders in if you gain 3 [three] gain 5 [five] pounds	ospital and 108 lbs on ospital discharge orders dated she received atenolol 50 d diovan for hypertension. The structed to "call your physician pounds or more over night, or a in a week" The orders also on 11/20/13, for a follow-up					
	a problem of hyper anti-hypertensive n medications). The her medical practiti of malignant hypert headache, visual pr difficulty breathing. R50 had a history of	plan dated 11/27/13, identified tension and received hedications (blood pressure plan instructed staff to notify oner of any signs or symptoms ension including the following: roblems, confusion, and The care plan did not indicate of congestive heart failure and retention and weight gain.				•	

RM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 66 of 120

	MENT OF HEALTH	AND HUMAN SERVICES			0	FORM AF	PROVED 938-0391
	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		245375	B: WING			12/20)/2013
AME OF P	ROVIDER OR SUPPLIER			STF 142	REET ADDRESS, CITY, STATE, ZIP CODE		
TERLIN	G PARK HEALTH CA	RECENTER		WA	AITE PARK, MN 56387 PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLÉTION DATE
F 309	Continued From pa Review of the facil Summary revealed 11/12/13 118 lbs (t discharge weight of 11/16/13 119 lbs 11/19/13 119 lbs R50's had a physic post her hospital of indicated R50's we physician commer some dyspnea (di extremity edema. hydrochlorothiazio high blood pressu When interviewed assistant director should have had of for symptoms for been placed on a sheet to monitor h completed. Even though R50 lower extremity ed the facility failed t symptoms of CHI 483.25(c) TREAT PREVENT/HEAL Based on the cor resident, the facil who enters the facil of a symptom so for the facility failed t symptoms of CHI 483.25(c) TREAT PREVENT/HEAL	age 66 ities Weights and Vitals I the following weights: up ten lbs from hospital on 11/11/13, one day prior) cian visit on 11/20/13, nine days lischarge. The office visit noted eight was 117 lbs. The nted R50 was up ten lbs and fficulty breathing) and lower The physician ordered de 25 mg daily (used to treat re and edema). I on 12/19/13, at 2:50 p.m. the of nursing (ADON) stated R50 continued ongoing monitoring congestive heart failure and n edema measurement flow her CHF, which was not had symptoms of dyspnea and dema with a ten lbs weight gain, o consistently monitor R50 for	F	309			
<u> </u>				Fa	acility ID: 00643 If continua	tion sheet F	Page 67 of 120

ORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00643 ,

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		& MEDICAID SERVICES		TIPLE CONSTRUC	TION	(X3) DA	TE SURVEY
	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	A. BUILDING			NPLETED
		245375	B. WING			12	/20/2013
AME OF	PROVIDER OR SUPPLIER	ф.			SS, CITY, STATE, ZIP CODE		
TERLIN	NG PARK HEALTH CA	RE CENTER		142 NORTH FI WAITE PARK	, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x (EACH	OVIDER'S PLAN OF CORREC I CORRECTIVE ACTION SHO REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314	prevent new sores i This REQUIREMEN by: Based on observation review, the facility for repositioning for 1 of with current pressure Findings include: R47's diagnoses, and 7/30/13, included paragenetic R47's diagnoses, and 7/30/13, included paragenetic required total assist of daily living (ADLs care area assesses dated 7/23/13, indiced develop pressures total bowel inconting repositioning. The admitted with and here ulcers on the right set During continuous of 6:50 a.m. to 9:42 a. R47 was lying on hift head of bed was slift time, R47 was not relicensed practical no room and administer feeding tube. At 8:	Trom developing. NT is not met as evidenced ion, interview, and document ailed to offer or provide timely of 2 residents (R47) reviewed re ulcers. Is listed on the care plan dated aralysis and stage two ne admission Minimum Data /17/13, identified R47 had no nt, was dependent upon, and tance of two staff for activities b), including repositioning. The ent (CAA) for pressure ulcers, ated R47 had a severe risk to ulcers related to quadriplegia, ence and [R47's] refusal of CAA also indicated R47 was ad two current pressure scapula. bservation on 12/18/13, from m., (2 hours and 52 minutes), is back, atop his bed, with the ghtly elevated. During this repositioned. At 7:59 a.m., urse (LPN)-B entered the ared medications to R47 via a 17 a.m., LPN-B completed	F3	The p of corn not co interpr agreer of the set for deficie prepar execut of state Withou statem respec 1.	reparation of the follow rection for this deficien nstitute and should no eted as an admission ment by the facility of t facts alleged or conclu th in the statement of ncies. The plan of cor ed for this deficiency w ed solely because pro- e and federal law requi t waiving the foregoing ent, the facility states w t to: Resident #47will have comprehensive skin assessment complete 1/24/14 and care plan be updated according Residents with curren pressure ulcers will be reassessed and care updated accordingly b 1/24/14. Staff educated during abatement plan on ho identify residents care planned interventions care sheets, as well as new interventions will communicated.	cy does t be nor an he truth sions rection vas visions re it. y with e ed by n will ly. t e plan by w to on the s how	
	licensed practical n room and administe feeding tube. At 8: R47's medication a room. LPN-B did n in the resident room	urse (LPN)-B entered the ered medications to R47 via a				be	

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OLDER TEND OF CONSIDEREST PUERCIA INSTRUCTION (20) MULTIPLE CONSTRUCTION A BULDING (20) MULTIPLE CONSTRUCTION A BULDING NMP FLAM OF CORRECTION 245375 a WNO 1220/2013 NMM COF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET 1220/2013 VALUE OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET 1220/2013 VALUE OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET 1220/2013 VALUE OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET 0 VALUE OF RECOMPTIENT RECOLLATORY OR LSC DENTIFYING INFORMATION 175 STREET ADDRESS OF OTHER WITTER CODENT ACTION BROULD BE CROSS REFERENCED TO THE APPROVEMENT CROSS REFERENCED T			AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER. STREET ADDRESS. CITY. STATE. STREET ADDRESS. CITY. STATE. STREET ADDRESS. CITY. STATE. CODE YAG ID. PREFIX. SUMANARY STREMENT OF DEFICIENCIES. INCOMPACTION INST EE PRECEDED BY FULL. PREFIX. D PREFIX. PREFIX. CODRECTION INST EE PRECEDED BY FULL. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECEDED BY FULL. PREFIX. PREFIX. CODRECTION INST EE PRECEDED BY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECEDED BY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECEDED BY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECED DY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECED DY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECED DY FULL. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECED DY FULL. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INST EE PRECED DY FULL. PREFIX. PREFIX. PREFIX. PREFIX. PREFIX. CODRECTION INSTERMENT OR DATE. CODRECTION INSTERMENT OR DATE. CODRECTION INSTERMENT	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COM	E SURVEY PLETED
TERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 56387 PREVEX SUMMAY STATEMENT OF DEPICIENCES READ DEPICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSG DEPICIENCIES OF ULL REGULTORY OF USE OF ULL REGULTORY OR LSG DEPICIE			245375	B. WING			12/2	0/2013
Continued Trad Continued From page 68 (NA)-D entered R47's room, noted an odor and immediately called for assistance. At 9:42 a.m., NA-C entered the room, and assisted NA-D with continence care and repositioning of R47. Observation of R47's coccyx, and back at this time revealed no creasing, redness or other indication of pressure or irritation. Bandages to R47's existing pressure ulcers near the right scapula remained intact. F 314 During an interview on 12/18/13, at 9:43 a.m., NA-D outing an interview on 12/18/13, at 9:43 a.m., NA-D verified that R47 needed to be repositioned every two hours per the plan of care, and added that [R47] often refused to be turned. NA-D did not fknow why [R47's repositioning] was not offered that morning, and stated, "That's not typical for us." NA-D baid that R47 should have been offered repositioned or off-loaded per TTT [Tissue Tolerance Test- a test used to measure tissue profusion] every hour recommended dif (Lieu to) presence of pressure ulcers, ned included various interventions that directal." [R47' area to profusion] every hour recommended dif (Lieu to) presence of pressure ulcers, newever. [R47'] compromised at 2 hours. Respect [R47's] right to decline this while explaining insk/benefits." The Group-ANA worksheet, dated 21/18/13, circted staff to turn and reposition [R47] every two hours and PRN (as needed). Completion date: January 24, 2014					14	42 NORTH FIRST STREET		
 (NA)-D entered R47's room, noted an odor and immediately called for assistance. At 9:42 a.m., NA-C entered the room, and assisted NA-D with continence care and repositioning of R47. Observation of R47's coocyx, and back at this time revealed no creasing, redness or other indication of pressure or irritation. Bandages to R47's existing pressure ucleers near the right scapula remained intact. During an interview on 12/18/13, at 9:43 a.m., NA-D could not recall when R47 was last repositioned, but stated that the dabeen longer than two hours. In an interview at 10:33 a.m., NA-D verified that R47 needed to be repositioned every two hours per the plan of care, and added that [R47] often refused to be turned. NA-D did not know why [R47's repositioning] was not offered that morning, and stated, "That's not typical for us." NA-D said that R47 should have been offered repositioned per TTT [Insue Tolerance Test- a test used to measure tissue profusion] every hour recommended dfi [Que to] presence of pressure ulcers, nowever, [R47] compromised at 2 hours. Respect [R47's] right to decline his while explaining risk/benefits. "The Group-A NA worksheet, dated 12/18/13, directed staff fo turn and reposition [R47] every two hours and PRN (as needed). A review of a weekly wound documentation note from 12/17/13, indicated two healing, stage three, pressure ulcers on R47's right scapula, with pink, intext surrounding skin, and minimal 	PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT	BE	
from 12/17/13, indicated two healing, stage three, pressure ulcers on R47's right scapula, with pink, intact surrounding skin, and minimal	F 314	(NA)-D entered R4 immediately called NA-C entered the r continence care an Observation of R47 time revealed no cr indication of pressu R47's existing pres scapula remained i During an interview NA-D could not rec repositioned, but st than two hours. In NA-D verified that F every two hours pe that [R47] often refu- not know why [R47 offered that mornin typical for us." NA- been offered repos R47's care plan, las identified the press various intervention be repositioned or of Tolerance Test- a te profusion] every ho presence of pressu compromised at 2 f decline this while ex Group-A NA worksf staff to turn and rep and PRN (as needed	7's room, noted an odor and for assistance. At 9:42 a.m., oom, and assisted NA-D with d repositioning of R47. "s coccyx, and back at this easing, redness or other are or irritation. Bandages to sure ulcers near the right ntact. To n 12/18/13, at 9:43 a.m., all when R47 was last ated that it had been longer an interview at 10:33 a.m., R47 needed to be repositioned r the plan of care, and added used to be turned. NA-D did 's repositioning] was not g, and stated, "That's not D said that R47 should have itioning, even if he refused. At reviewed on 10/16/13, ure ulcers, and included us that directed, "[R47 was to] off-loaded per TTT [Tissue ast used to measure tissue ur recommended d/t [due to] re ulcers, however, [R47] nours. Respect [R47's] right to xplaining risk/benefits." The beet, dated 12/18/13, directed oosition [R47] every two hours ed).	F	314	 complete 2 audits weekly for one month, then one audit weekly for 2 months 5. The data collected will be reviewed/discussed at the monthly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies and required audits 	5	
		from 12/17/13, indic pressure ulcers on	cated two healing, stage three, R47's right scapula, with pink,					

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DEPART		AND HUMAN SERVICES				FORM A MB NO.	01/10/2014 APPROVED 0938-0391
TATEMENT (S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245375	B. WING			12/2	20/2013
	ROVIDER OR SUPPLIER	RE CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	The superior (upper centimeter (cm) x (lower) wound mea A review of the wea 10/29/2013 to 12/1 evidence the press During interview of LPN-C said that Re and that R47 was treatment. LPN-C were in the care pl had pressure ulcer on a two-hour repo of care. LPN-C said develop pressure 1 "dependence, imm LPN-C also ackno	ainage from the lower wound. er) wound measured one (1) 1 cm x 0 cm; and the inferior asured 0.6 cm x 0.5 cm x 0 cm. ekly wound notes from 7/2013 further indicated sure ulcers were healing. n 12/17/13, at 10:31 a.m. 47 preferred to lay on his back, often non-compliant with added that R47's preferences an. LPN-C confirmed that R47 rs on his upper back, and was ositioning schedule per his plan id R47 was at high risk to	с.	314			
F 323 SS=J	During an interview the director of nur- needed to repositi ulcers according to said it was "essen timely, and she "e followed for reside A facility policy res pressure ulcers w provided. 483.25(h) FREE C HAZARDS/SUPE	w on 12/18/13, at 10:36 a.m., sing (DON) stated the NAs on residents with pressure o the plan of care. The DON tial" residents be repositioned xpected the care plan be ents with pressure ulcers." garding care of residents with as requested; none was DF ACCIDENT RVISION/DEVICES ensure that the resident ains as free of accident hazards		323	F323 The preparation of the followin of correction for this deficiency not constitute and should not be interpreted as an admission not agreement by the facility of the of the facts alleged or conclusi set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provit of state and federal law requires Without waiving the foregoing statement, the facility states warespect to:	does be a truth ons ection as sions e it.	

RM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

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If continuation sheet Page 70 of 120

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

PRINTED: 01/10/2014 FORM APPROVED OMB NO: 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
	· · ·	245375	B. WING		12/20/	201
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE CO	(X5) DMPLE DATE
F 323	as is possible; and	ge 70 each resident receives on and assistance devices to	F 323	for fall risks upon by n 12/20/13, to assure th	ssed oon	•
- - - - - - - - - - - - - - - - - - -	by: Based on observati review, the facility fa were comprehensive interventions implem 5 residents (R32, R4 with falls. The facili comprehensively as determine if new inte implemented, nor did interventions were co consistently implement which resulted in mu significant head injur failure resulted in an serous harm and injur addition to the reside the facility failed to co resulting in potential failed	nented to prevent falls for 4 of 48, R11 and R66) reviewed ty failed to investigate and sess resident falls to erventions could be 4 the facility assure the urrently in place or were ented in preventing falls litiple fractures for R32 and a y for R48. The facility's immediate jeopardy, with my for R32 and R48. In nts in immediate jeopardy, omprehensively assess falls for harm that that was not or 2 out of 5 residents (R11		 assessment is comprehensive and to ensure that residents I appropriate interventio are being utilized. 2. All incidents are review by DNS and/or ED or designee upon notificat for appropriate interventions, to assure care planned approach were being followed, and review for possible vulnerable adult reporti 3. All incidents are review by facility Inter Disciplin Team (IDT) for appropriateness of interventions and any necessary modifications residents plan of care. 	nave ns ved tion e that es nd to ng. ed ary	
1 c ir a n ir	dministrator, director urse, and executive nmediate jeopardy (]	cility failed to				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONS				ATE SURVEY
		245375	B. WING	• •		· .	1:	2/20/2013
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, ST.			
STERLI	NG PARK HEALTH CA	RE CENTER			TH FIRST STREE			
		· · · · · · · · · · · · · · · · · · ·	× .	WAITE	PARK, MN 5638	7.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIV ROSS-REFERENCE) BE	(X5) COMPLET DATE
F 323	Continued From page	ne 71	F 3	23	4. All facility s		· · · · · · · · · · · · · · · · · · ·	
	removed on 12/20/1			20	meetings he	at employee eld 12/19/13 at		
	and severity level, or immediate jeopardy.	f actual harm that was not			0600, 0700	200, 12/20/13 0830, 1100,	at	
	Findings include:				and 1400. E unable to at	tend were	•	
					educated vi prior to next	scheduled sh	ift	
	significant fractures.	ne past 10 months, with The facility had not			education m	eive packet of naterials prior t ext scheduled	D	
	compressively asses consistent intervention falls for R32, which r	sed, or implemented ons to decrease the risk of esulted in an immediately			shift. No em allowed to w	ployee will be ork unless		
	jeopardy.				education ha	as deen		
	9/26/13 identified R3	um Data Set (MDS) dated 2 had moderate cognitive						
	activities of daily livin was frequently incont	extensive assistance with g (ADL's) except eating, and inent of bladder					,	
	R32 was currently in	an assessment period and ne Care Area Assessment					. .	
	(CAA) related to falls	dated 12/12/13 which t high risk for falls due to						
	history of multiple fall decision making, inat	s, incontinence, impaired						•
	concerns, orthostatic and Parkinson's disea	blood pressure changes, ase with shuffling gait and					-	
0	days' and 'bad days.' .	esident does have 'good At times resident will lean						
0	control and she does.	eelchair due to poor trunk have a positioning cushion				· .		· -
r	ollback device on wh	sident does have anti eelchair. Alarms and safety						-
16	ength and negotiated	liscussed with family at risk is in place. Family						. ,
a	and would like her to b	tations on residents mobility be allowed to freely move in not want resident to feel			•	•		

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			ON	FORM / /IB NO.	APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245375	B. WING			12/2	0/2013
	ROVIDER OR SUPPLIER G PARK HEALTH CA	TEMENT OF DEFICIENCIES	ID	14 W	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
F 323	consequences of re R32's care plan dat "is at risk for falls re with behavioral dist decisions, and nee- toileting. Had fall o and pelvic ring frac due to fall 9/17/13.' were "Anti-rollback prevent any falls toileting more than before meals, and repositioning to pre- to TABS alarm plac room close to nursi frequent monitoring product on top of w sliding out of wheel pedals when not be like phone placed of morning to ease ac her reach when in land The current nursing dated 12/17/13 whi use to provide care "assist resident to I posture and betwee walking independe not force to sit in w assure over bed ta when leaning. Rep	ay. Family does understand esident falls." ted 10/29/13 indicated resident elated to history of Parkinson's surbance, poor safety d for assist with ADL's and n 5/1/13 with right hip fracture turepelvic fracture 9/20/13 ' The facility interventions mechanism to wheelchair to has asked not to offered upon rise, HS (hour sleep), with staff assisted event falls family is opposed ement for fall notification ing station to facilitate more g for self transfers non-slip theelchair cushion to prevent lchair, remove wheelchair eing propelled by staff would on bed after bed is made in ecess ensure remote is within		323	 Staff will be informed of new interventions and changes to plan of care will be placed on the white communication board and the 24 hour report. SPHCC fall protocols, have been reviewed and no changes have been made Nursing staff re-educated on safety interventions for residents at risk for falls including: not leaving residents identified as high risk unattended in a bathroom consider PT/OT assessment medication review by pharmacist environmental review assistive devices that may be appropriate safety devices such as antiroll back device, nonskin products, anti tip bars on w/c protective devices such as fall mat, low bed Additional monitoring for toileting needs, infections, etc 		
	purpose of this neg	jotiated risk agreement is to	<u> </u>			n abaat D	

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6U1311

Facility ID: 00643

If continuation sheet Page 73 of 120

					. PF	RINTED:	01/10/2014 APPROVED
DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OI	MB NO.	0938-0391
TATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245375	B. WING		ı ·	12/2	20/2013
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	G PARK HEALTH CA	RECENTER			AIZ NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	describe residents following issue: Wa use of a wheel wal which parties ackn his/ her resident rig agreement will ider outline the risks an residents choice, id decrease risk, and agreement betwee Consequences ind in injury up to and agreement betwee resident final choic risks and the plan follows: staff will g witnessing a poter to ensure safety w comfort or right to During observation R32 was sitting in The call light was the bedside table and the phone wa leaning over trying the floor. The whe each time the resid attempt to pick up surveyor requeste assistant (NA)-B. During interview of stated R32 will us She stated if staff front of her with al generally not mov wheelchair. NA-B	choice with respect to the alking independently with the ker, or pushing her wheelchair owledge is a valid exercise of phts. The negotiated risk ntify the residents choice, d possible consequences of dentify alternatives offered to then describe the final in the parties. Risks: lude: falling, falling may result including death. Final in the parties evidencing the following a discussion of the of action to decrease risk is as live verbal cues on safety when tial risk and may shadow [R32] hile not encroaching on [R32]		1	 8. Staff education regarding implementation of hourly customer service rounds be completed by January 24, 2014 9. Root cause analysis completed with all falls an is reviewed weekly at fall committee meetings. 10. The data collected will be reviewed/discussed at the monthly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies and required audits 	ıd	
<u>.</u>	Set up decerding			Fa	acility ID: 00643 If continuat	ion sheet	Page 74 of 120

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Facility ID: 00643

If continuation sheet Page 74 of 120

		AND HUMAN SERVICES			\checkmark	FORM	01/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245375	B. WING			12/2	20/2013
NAME OF F	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
OTEDLIN	G PARK HEALTH CA	RECENTER			142 NORTH FIRST STREET		
SIERLIN	G PARK HEALIN CA		-		WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	falls. During observation R32 was sitting in h The bedside table v the telephone on it around the grab ba 4-5 feet away from reach these items. wheelchair cushion slip pad observed of During interview on stated she needed she has to use the is unable to get to h to the bathroom by During interview on director of nursing (have her bedside ta the telephone, new call light within reac not always use her go to the bathroom. R32's room, the res help me to the bath During observation was observed sittin room. The call light her approximately to on the bed and the newspaper. The re and there was hock was no anti slip mat	nt of the resident to prevent on 12/18/13 at 10:20 a.m. her wheelchair in her room. was sitting against the wall with and the call light was wrapped r on her bed, both were about R32, and she was unable to R32 was sitting on a however, there were no anti on the wheel chair cushion. 12/18/13 at 10:25 a.m. R32 to turn the call light on when bathroom but sometimes she her call light so she just goes	F	323	Plan of Correction for R32Fall Risk Assessment completed19-13. Risk factors identified, careplan and care sheets reviewed arupdated with current interventionsOccupational Therapy Evaluationwheelchair positioning,environmental adaptations andsafety that may reduce fall riskcompleted on 12-19-13 and willcontinue to be ongoing.Will try a larger table for R32 tokeep papers and other belongingon that is stationary. Trial will beongoing to determineappropriateness.Fall prevention Interventions:• Necklace pendant given toR32 at 5:00pm on 12-19-1Resident and daughter weeducated on use ofpendant. Flow sheet withhourly documentation onpendant use and toleranceinitiated.• Every fifteen minute checkinitiated 7:00pm on 12-19-13. Flow sheet started tomonitor checks.Monitoring will be ongoingto determine if interventionare appropriate andimplemented consistently.	e nd s. for s s J J J J J J S. ere	
	and there was hock was no anti slip mat	ey on the television. There t observed on R32's					

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

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If continuation sheet Page 75 of 120

PRINTED: 01/10/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245375	B. WING	· · · · · · · · · · · · · · · · · · ·	12/20/2013
	DER OR SUPPLIER .RK HEALTH CA	RE CENTER	· -	STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFIGIENCY)	D BE COMPLETION
Duri nurs light new all or mat not v care top c resid Durir was sleep whee	e verified R32 v available as we spaper, and pho ut of reach. MD was under the v risible. MDS nu indicated R32 v f the wheelchai ent from slippin og observation o n her room sitti ing. The bedsi lchair with the r	ge 75 12/18/13 at 1:20 p.m. MDS vas suppose to have the call as the remote control, one; and they were currently S nurse stated the anti slip vheelchair cushion and it was rse was not aware the plan of was to have a anti slip mat on r cushion to prevent the g out of the wheel chair. on 12/19/13 at 8:50 a.m. R32 ng in her wheelchair de table was behind her remote control on it. The call ound the grab bar on the bed	F 323	 3 day Bowel and Bladder Log initiated 12-19-13 at 11:00pm. Anti-rollbacks on Wheelchair Remove wheelchair pedals in room, attempt to put on when transporting- R32 wil refuse to have them on at times. Do no leave unattended of the toilet. Offer toileting between hours of 2:00pm and 	
which Durin R32 v sleep whee light v feet a Recol Febru	n was about fou g observation c vas in her room ing. The bedsic lchair with the n vas pinned to th way from the re rd review identif ary 2013- Dece	r feet behind the resident. n 12/19/13 at 11:20 a.m. sitting in her wheelchair de table was behind her emote control on it. The call e bed, approximately 3-4 sident. ied R32 had 23 falls from- mber 2013. The facility		 4:00pmas this was a time identified by IDT team as pattern of fall time. Cushion with anchors placed in wheelchair. Keep items off the floor. Encouraging R32 to come out of her room more ofter and to engage resident with others to help reduce falls. 	a n ih
Progra which fall. T 2/5/13 floor o the ba trying	ess Notes, and the facility state he falls were re - 11:30 a.m. "R f her room on h throom door. R to fill her pop bo	a Resident Incident Report, a word document untitled ed was a "summary" of each viewed as follows: esident was found on the er hands and knees near esident stated that she was ottle with water in the as not incontinent at time of		 Pharmacy will review medications on 12/20/13 Social Service and Community Life will reassess for programs to trial b 12/20/13 at 1200, evaluation of effectiveness to be ongoing. Interventions identified to try based on residents social history and prior assessment will include: 	y

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6U1311

Facility ID: 00643

If continuation sheet Page 76 of 120

PRINTED: 01/10/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVI COMPLETED
	- 	245375	B. WING		12/20/201
	(EACH DEFICIENC)	RE CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLI
F 323	a.m. which is appro Again, family does r interventions which way from getting up During interview on stated no new interv after the fall on 2/5/ her Parkinson's med the fall was related t 2/8/13- 12:00 p.m. " of her room sitting a stated she was tryin roommate to talk wit Residents roommate of fall Resident wa fall and her pad was want to add any fall i	priate per her care plan. not want to add any fall would restrict resident in any	F 323	 Sorting and organizing items Increased 1:1 time from 5 times per week- Mon, Wed, Friday between 2-Tuesday and Thursday a various times as a trial. attempt 1:1 outside of the room. Family visits almost data continue to ask them for ideas on interests and activity preferences. Bookkeeping items-calculator, pens Will look for smaller gromactivities and encourag resident to attend. 	4, at Will e ly- or any
i i s f c f	stated no new interver after the fall on 2/8/1 her Parkinson's medi the fall was related to 2/15/13- 4:00 p.m. "R room sitting next to h also near the residen resident had been in attempting to self trans the fell Resident was all and denied need to deny use of any device rom getting up on he	2/17/13 at 11:00 a.m. DON entions were put into place 3 because R32 had refused cations and the facility felt o not taking her medications. tesident was found in her er bed. Wheelchair was t and it appeared that the her wheelchair and was usfer out of wheelchair when as not incontinent at time of to use toilet Family again tes that would restrict [R32] r own."		Plan of Correction R48 New Fall Risk Assessment completed 12-19-13. Risk facto indentified, care plan and care sheets reviewed and updated w new interventions. Occupational Therapy order to Evaluate for Strengthening, Balance, safety with walker and environment for any adaptations and modifications that may redu fall risk on 12/20/13.	rith s

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 77 of 120

PRINTED: 01/10/2014 FORM APPROVED OMB NO: 0938-0391

	RS FOR MEDICARE & MEDICAID SERVICES		(<u>IMB NO.</u>	0938-039
	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
	245375	B. WING		12/5	20/2013
NAME OF	PROVIDER OR SUPPLIER	· 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
OTEDIU			142 NORTH FIRST STREET	•	
SIERLI	NG PARK HEALTH CARE CENTER		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
ci is v f t	of her room by staff. Fall was unwitnessed, It appeared that resident attempting to self transfer from her wheelchair Staff toileted resident approximately one hour prior Again, family does not want further interventions to restrict resident from self transferring even with risks explained." During interview on 12/17/13 at 11:00 a.m. DON stated no new interventions were put into place after the fall on 2/15/13 because R32 had refused her Parkinson's medications and the facility felt the fall was related to not taking her medications. 2/18/13- 3:15 p.m. "In review of video, appeared resident grabbed rail in hallway and was sliding out of her wheelchair, attempted to stand, wheelchair slid out from behind her and resident fell to the floor No cushion or Dysum [anti slip mat]" The intervention listed was, "Make sure anti slip product and cushion are in wheelchair at all times." During interview on 12/17/13 at 11:00 a.m. DON stated the intervention to add the cushion in R32's wheelchair and the Dysum were initiated on 2/18/13. DON verified R32's plan of care indicated the Dysum was dated on 2/12/13 as the start date, however, DON was not able to identify where that start date came from. 3/4/13- 9:20 p.m. "Resident was found on the floor of her room next to her closet. It appeared hat resident had been in her wheelchair	F 323		13. nt d. n ns	
v F p p	previously and slid out of wheelchair as wheelchair found directly behind resident. Resident was last toileted at 2:30 p.m Staff did place nonskid pad in residents wheelchair to prevent her from sliding out of wheelchair in the uture." Included in the Incident investigation was		 activity or time of day. Sleep monitoring will be initiated after weekly blood pressure are completed on 12/27/13 		

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 78 of 120

PRINTED: 01/10/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375 NAME OF PROVIDER OR SUPPLIER 245375 STERLING PARK HEALTH CARE CENTER STERLING PARK HEALTH CARE CENTER		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
			B. WING		12/20/2013
		STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
	the resident was we resident had been of toileting at 4:00 p.m resident had refuse During interview on stated the intervent slip pad to the resid verified this was the after the prior fall or was no further invest was not in R32's who of care. 3/13/13- 3:15 p.m. " room on her hands gently slipped off he knees when she wa up" There was no cushion or Dysum w summary of the fall Practitioner] was he chest X-ray and vari increased confusion sounds." Review of the chest R32 was found to ha second through sixth bottom of the X-ray I was on 3/14/13 a me physician and NP, at results were faxed to However, there was NP or physician, nor	at at the time of the fall and the offered assistance with . and 7:00 p.m. but the d. 12/17/13 at 11:00 a.m. DON on was to place a Dysum non ents wheelchair. DON intervention put into place 2/18/13. DON stated there stigation as to why the Dysum eelchair according to the plan Resident was found in her and knees. She stated she r wheelchair and fell to her s trying to pick something indication if the anti slip ras in the wheelchair. The ndicated, "On 3/14/13 [Nurse e for rounds and ordered a ous other orders due to and decreased breath X-ray dated 3/14/13 indicated we "fracture of the left ribs." Handwritten on the by a [unknown] facility nurse issage was left with R32's ad on 3/15/13 a copy of the R32's physician and NP. no follow up note from the was there any assessment how R32 received four	F 32	 Encourage resident to attend activities out of room, especially in the evening hours to help promote nighttime sle Resident Community Assessment was reassessed 12/20/13. Fifteen minute checks hourly pendant monitor will be reviewed by ID patterns, findings, and appropriateness of interventions. Change monitoring will be determined by the IDT based on the data colle Licensed staff will be responsible on each stensure all staff is consistently implement care planned interventi. DNS and ED are responsible to ensure p of correction completed Correction will be comp by 1200 on 12/20/13. 	her e ep _ife and ring T for s to ected. aift to ing pons. lan lete

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6U1311

Facility ID: 00643

If continue tion sheet Page 79 of 120

	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 01/10/201 FORM APPROVE OMB NO. 0938-039
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		245375	B. WING		12/20/2013
	ROVIDER OR SUPPLIER	RE CENTER	14	REET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET 14ITE PARK, MN 56387	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	stated after the fall and ordered a ches breath sounds. Sh revealed R32 had 4 facility had no inves with the NP or the p broken ribs. DON with pneumonia an and an Exelon (me No new specific fal implemented at this There was no indic completed to deter	12/17/13 at 11:00 a.m. DON on 3/13/13 the NP saw R32 at X-ray related to decreased e stated the chest X-ray 4 broken ribs, however, the stigation or communication ohysician regarding R32's stated R32 was diagnosed d was started on antibiotics dication for memory) patch.	F 323		
	3/15/13- 7:10 p.m. on the floor in her r had gotten up and independentlyRe	"Resident was found by staff oom. It appeared that resident was ambulating sidents [family] does continue risk in place and would like			
	stated after the fall completed a 3 day assessment. DON voiding noted so th	n 12/17/13 at 11:00 a.m. DON on 3/15/13 the facility bowel and bladder diary and stated there was no pattern of e residents toileting schedule ry 3 hours and as requested by			
•	her left side on the toileted was 'after l time of fall." During interview or	"Resident was found lying on floor of her roomLast time unch.' Resident was dry at 12/17/13 at 11:00 a.m. DON sure the specific time R32		· · · ·	
RM CMS-2	stated she was not		1 Fac	ility ID: 00643 If continua	tion sheet Page 80 of

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	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	01/10/2014 APPROVED 0938-0391	
DEPARTMENT OF HEXET IN A MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION		B. WING	i		12/20/2013		
		245375		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	ROVIDER OR SUPPLIER				2 NORTH FIRST STREET			
STERLIN	G PARK HEALTH CA	ARE CENTER			AITE PARK, MN 56387 PROVIDER'S PLAN OF CORRECT	ION	(X5)	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLÉTION DATE	
F 323	as this was not pa investigation. DO were implemented 3/27/13- 7:50 p.m room, lying on her Stated she put her knelt on the floor lie down on the floor lie down on the floor make sure they a During interview stated on 3/27/13 R32's room to en appropriate for the included ensuring reach, the tray ta telephone, news control for the tel the residents rea 3/29/13- 6:30 a.r with legs in bath on the carpet in was coming out down.'Residen negotiated risk t would restrict her During interview stated no specifi implemented aff	Attention of the fall on 3/16/15 rt of the initial incident report N verified no new interventions d after the fall on 3/18/13. . "Resident was found in her r left side next to her wheelchair r newspapers on the floor, then to pick them up and decided to bor" The investigation also dents phone was on the floor. put into place were, "Assess for t of items resident may need; are within reach." on 12/17/13 at 11:00 a.m. DON the facility nurses observed usure the "room setup" was ne resident. DON verified that g the residents call light is withir uble be placed in front of R32 wir paper, pop/water, and remote levision on the table and within	r hth e."	323			act Page 81 of 12	
		Event ID:6	J1311		Facility ID: 00643 If con	tinuation sh	eet Page 81 of 12	

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)EPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM / MB NO.	01/10/2014 APPROVED 0938-0391
	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245375	B. WING			12/2	20/2013
	ROVIDER OR SUPPLIER G PARK HEALTH CA			1	BTREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	the floor in her roo over-turned tray ta placement of items rearranged approp During interview o stated she did not attempting to do n residents room wa this wasn't part of stated there were in place after the f thought the reside her Parkinson's m DON stated educ ensure R32's call she was unable to completed as she her call light near 4/22/13- 6:30 p.m on the floor in her describe what she Resident was sitt against the door next to her in the prior to supper, 4 bladder at time o alarms or interve continues to wish that could limit re move when she During interview stated resident h	"Resident was found sitting on m next to her wheelchair and ble Assessed room for s resident may be reaching for, oriately." n 12/17/13 at 11:00 a.m. DON know what the resident was or was she sure how the as arranged prior to the fall as the assessment. The DON no specific fall interventions put fall on 3/31/13 because she ent had been refusing some of nedications prior to the fall. The ation was done with staff to light was within reach, however o verify why this education was a was not sure if the resident had her at the time of her fall. n. "Resident was found by staff room. Resident was unable to e was trying to do prior to falling ing with her back leaning up to her room, her wheelchair was upright positionlast toileted :30 p.m., and was incontinent of fall. Have discussed use of ntions for falls with daughter, n to not have anything in place usidents ability to transfer or wishes to." on 12/17/13 at 11:00 a.m. DON ad been refusing medications stated there was no further nterventions implemented after 3.	, , , f	323		nation shee	t Page 82 of 12

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A MB NO. (01/10/2014 PPROVED)938-0391
	S FOR MEDICARE OF DEFICIENCIES = CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245375	B. WING			12/20/2013	
	ROVIDER OR SUPPLIER G PARK HEALTH CA		L	14	REET ADDRESS, CITY, STATE, ZIP CODE 22 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
TAG	REGULATORY ON L		1				
F 323	Continued From pa		F	323			
	her right side, up a was unable to repo was trying to do pr a.m. and was cont complained of righ contacted the phys displayed a hip fra R32 was transferr and returned on 5 after this fall was	Resident was found lying on against the closet. Resident ort what occurred or what she for to fall last toileted at 5:30 inent at time of fall Resident it hip pain." The facility sician to obtain an X-ray which icture and pelvis displacement. ed to the hospital for surgery /4/13. The facility intervention rassure resident is set up with she may need (snack,			Y.	•	
	a "right intertrocha roughly 6 mm (mil Fractures of the ri rami are again no displacement com	dated 5/1/13 identified R32 had anteric hip fracture with up to llimeters) of displacement ght superior and inferior pubic ted. There is increased npared to prior exam. An ala fracture is suspected but certainty."		·			
	stated the interve kept the residents stated the investig items were place she fell on 5/1/13						
	comprehensively	E		F	Facility ID: 00643 If continua		Page 83 of 120

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		AND HUMAN SERVICES	·			FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY
		245375	B. WING			12/	20/2013
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET /AITE PARK, MN 56387		
<u></u>		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLÉTION DATE
F 323	floor in her room or been repositioned I leaning in her whee recognized resident wheelchair. The st a safe position, and When staff returne When resident is d are to assist her to During interview or stated the resident medications on 5/2 to lay resident dow her wheelchair. 6/1/13- 11:00 a.m. sitting on her bottoo on her elbows. Re self-transfer and st floorResident wa was incontinent at offered toileting eve provided to NA." T where the resident cushion was in the During interview or stated the resident medications on 6/1 sure if the resident wheelchair cushior investigation. 6/16/13- 5:15 p.m. her right side with I attempting to reach	"Staff found resident lying on her right sideResident had by staff multiple times due to elchair NA staff member it was leaning forward in her aff member repositioned her to d then went to get assistance. d she was laying on the floor isplaying poor posture, staff bed." 12/17/13 at 11:00 a.m. DON had refused her Parkinson's 1/13, and staff was instructed n in bed if she was leaning in "Resident was found by staff m near the bathroom, leaning	F				
	567(02-99) Previous Versions		<u>I</u>	Fac	cility ID: 00643 If continu	ation sheet F	age 84 of 120

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0	MB NO.	APPROVED 0938-0391	
ATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245375	B. WING			12/20/2013		
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387			
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JRF	(X5) COMPLETION DATE	
F 323	of wheelchair. Wa from left hip to upp ambulance was ca injuries. Educated brakes for the whe this time." During interview o stated anti lock bra wheelchair after th she was not sure residents chair as investigation. 8/18/13- 4:15 p.m floor of her room b gently lowered he from that shift resi through the shift. multiple times to b declining" During interview o stated resident wa leaning in wheelch 8/25/13- 2:10 p.m the floor of her rooy yelling 'help me!' doing she stated ' appeared as if resi wheelchair. Resident wa	ece of paper away and slid out s complaining of severe pain ber right side of her body liled no fractures or other family on use of anti-roll back belchair which were applied at n 12/17/13 at 11:00 a.m. DON akes were added to R32's the fall on 6/16/13. DON stated f the anti slip Dysum was in the this was not part of the fall . "Resident was found on the by NA. Resident stated she rself to the floor. Staff reports dent was leaning significantly Staff approached resident et down, but resident kept on 12/17/13 at 11:00 a.m. DON as educated to lay down while hair. . "Resident was found lying on om after staff responded to her When staff asked what she was reaching to turn the stove off.' I sident was previously in her dents water pitcher noted to be	5	323				
	on the ground and pitcher discusse therapy) or OT (o Previous interven evaluations which	d carpet was wet from water ed need for PT (physical ccupational therapy) evaluation. tions continue from last n include anti roll back brakes. Int to continue with staff				tion short	Page 85 of 120	

Event ID: 6U1311

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Facility ID: 00643

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		AND HUMAN SERVICES					FORM	: 01/10/2014 APPROVED . 0938-0391
TATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245375	B. WING)			12/	20/2013
NAME OF I	PROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE,	ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET NAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 323	approaching reside as this was making	ige 85 nt every hour to offer toileting resident more anxious and me therapy evaluation not felt	F	323				
	stated she was uns R32 to be toileted e However, she state requested staff to n go to the bathroom be bothered that off at this time R32's to upon waking, before bed. DON also stat	a 12/17/13 at 11:00 a.m. DON sure when the intervention for every hour was put into place. In the resident and her family not ask resident "so often" to as the resident didn't like to ten. DON stated she thought bileting plan was changed to e and after meals, and before ted she was unsure if the out of her bed or out of her						
	floor by the NA. Sh grasping her left hip severe painambul resident was transp hospital. Prior to he reported that she fo room. She entered back in her wheelch something the resid and stated, 'I need t nothing was noted t the floor nurse aske and resident stated here.' Resident had she needed to toilet had requested that resident as to not lin anti-roll back brakes toileting plan in place	"Resident was found on the be was lying on her back and b. groin area and expressing lance was contacted and borted to the St. Cloud er fall activity staff had bound resident standing in her the room and had resident sit hair, and asked if there was lent needed. Resident pointed that over there,' though to be presentWhen found on ed what she was trying to do she was trying to 'get out of been asked at 4:00 p.m. if t but resident refused. Family no alarms be placed on mit her mobility. Resident has s applied to her wheelchair, ce and followed correctly." o the facility from the hospital						
	67(02-99) Previous Versions		1	Fac	Lility ID: 00643	If continuation	aboot D	

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		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·····				<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE ÇONSTRUCTION		TE SURVEY MPLETED
		245375	B. WING			12	/20/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA				142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	9/17/13 indicated R identified "evidence	a Admission note dated 32 had a pelvis X-Ray which of old right hip fractures with	F3	323			
	ramus and parasyn	es of the left inferior pubic nphyseal region of the left vas admitted to the hospital.					
	stated the facility di place after the fall v did the facility invest	12/17/13 at 11:00 a.m. DON d not put new interventions in vith fracture on 9/17/13, nor tigate the fall to ensure the cording to R32's care plan.					
	from her wheel chai	ation the facility had ssessed R32 multiple falls ir while in her room and tions to decrease R32 risk of			,		
	floor by NA sitting of sitting in front of her not incontinent at tir fall. Staff did see re independently previ intercept resident. S had slipped out of h of wheelchair behind	Resident was found on the n the floor. Resident was wheelchairResident was ne of fall, but did void post esident ambulating in her room ously during the shift and did Staff did question if resident er wheelchair due to proximity d the resident. Dycem non in residents wheelchair post					
	DON stated the Dyc was ordered on 2/18 and she was unsure wheelchair on 11/9/	12/17/13 at 11:00 a.m. the cem non slip material which 8/13 was never discontinued, a it was not in the residents 13. DON verified staff were care plan to prevent falls if the			, , , , , , , , , ,		

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Facility ID: 00643

If continuation sheet Page 87 of 120

PRINTED: 01/10/2014

	MENT OF HEALTH	AND HUMAN SERVICES	(FORM /	01/10/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		245375	B. WING				12/2	20/2013
	PROVIDER OR SUPPLIER		- I		TREET ADDRESS, CITY, STATE, ZIP COD	θE		
					42 NORTH FIRST STREET			
STERLIN	G PARK HEALTH CA	RECENTER		V	VAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 323	Continued From pa Dycem was not in p		F	323	- -			
	between her nights with back against th was just walking ar minutes prior to the During interview or stated no new inter after the fall on 11/2	"NA found resident on floor stand and table in her room he wall. Resident stated she round had been toileted 30 e fall" n 12/17/13 at 11:00 a.m. DON rventions were implemented 27/13 nor was the residents ed as part of the fall			-			
	the floor of her bath incontinent at time resident to the toile Resident had been times after supper declined each time on the summary of	"Resident was found by NA on hroom resident was not of fall and staff did assist et and she did void post fall. n approached by staff multiple to use the toilet and she e." This information was listed f the fall, however, the actual of identify when the resident						
	stated R32's plan of the resident to the however, she was plan was implement discontinued. DON reminded to use the assistance. DON state able to use her call with the use. The incident reports or the residents call lithe resident will oft	n 12/17/13 at 11:00 a.m. DON of care on 12/6/13 was to assis bathroom every 2 hours, unaware when this toileting nted and when it was N stated R32 was also the call light when she needed stated R32 was "sometimes" I light but was "inconsistent" DON also verified none of the the fall investigations include it ight was on or within reach, and then propel herself in her her room, so her call light is						
RM CMS-2	567(02-99) Previous Version		11	Fa	cility ID: 00643 If cont	inuatior	n sheet P	age 88 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING				20/2013
NAME OF F	ROVIDER OR SUPPLIER		_		REET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RECENTER			NORTH FIRST STREET		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	had never talked at pendent call light (c her neck), although call light system an the facility were cur light system. The more "aware" of R3 about doing hourly safety, but this was The DON stated R3	age 88 The DON stated the facility bout providing R32 with a one that could be worn around a the facility had the pendent d several other residents in rently utilizing the pendent call DON stated staff needed to be 32 and the facility had talked rounds to ensure all residents a not implemented for R32. 32 had been seen by both PT " for strengthening the last		323			
	FM-I stated she wa frequent falls and v call light is often in R32's reach. Howe sure the resident w	n 12/17/13 at 2:15 p.m. R32's as aware of the residents isits the resident often. R32's different places and not within ver, FM-I stated she wasn't rould always be cognitive call light when she needed					
	physical therapist (worked with R32 to 2013 for safe trans- time it was recomm	12/18/13 at 1:10 p.m. PT)-H stated he had last wards the end of October ferring. PT-H stated at that hended staff no longer walk instability and varying degrees day to day.					
	stated R32 was to I NA-D stated R32 w bedside table in fro control, phone, new stated the resident	12/18/13 at 1:05 p.m. NA-D be toileted every 2 hours. vas supposed to have her nt of her with her remote vspaper, and call light on. She roams around her room so yet to her call light when she Cobsolete		Facil	ity ID: 00643 If continu	lation sheet F	Page 89 of 120

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DEPART	MENT OF HEALTH					FORM. MB NO.	01/10/2014 APPROVED 0938-0391
TATEMENT	SFOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245375	B. WING			12/2	20/2013
	ROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET 1/AITE PARK, MN 56387		
(X4) ID PREFIX TAG	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 89	F:	323			
	occupational theral worked with R32 o OT-D stated in Mar toilet resident ever many falls were ner residents room. O family and R32 did because staff was stated she then red should be doing at the resident was sineeded. She was hour checks were OT-D stated she h the residents whee resident had been R32's wheelchair of reevaluated. OT-I had been slipping other cushions that may have prevent of the wheelchair. During interview of consultant (NC)-C investigation docu complete, R32's fa NC-C verified the documentation the R32's falls. Even though R32 months, with some significant fracture hospitalization. Th assessed, or imple	n 12/19/13 at 9:08 a.m. the pist (OT)-D stated she had n and off since May 2013. The y 2013 she recommended staff y hour because it appeared ar the bathroom in the T-D stated staff told her that not want the hour toileting "pestering" her to often. OT commended to staff they least hourly checks to ensure afe and had everything she unsure if and when the one implemented by the facility. ad anti lock brakes added to elchair, but was not aware the sliding out of the wheelchair so cushion had never been D verified if she was aware R32 out of the wheelchair there are it could have been tried which ed the resident from sliding out n 12/19/13 at 9:50 a.m. nurse stated although the mentation may not be alls were fully investigated. facility provided all the ey had available related to had 23 falls in the past 10 e of the falls resulting in es which required he facility had not compressively emented consistent ecrease the risk of falls for R32.					

Facility ID: 00643

If continuation sheet Page 90 of 120

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			(FORM A	APPROVED 0938-0391
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245375	B. WING			12/2	0/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	RECENTER			WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	۶IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 90	F	32:	3	-	
	which she sustained significant changes neurological exam comprehensively a consistently impler	rom 10/7 thru 11/24/13, in ed multiple head injuries with s in her vital signs and . The facility did not assess her falls and ment interventions to decrease hich resulted in an immediate					
	10/18/13, included hypertension, and R48 had severe co extensive assistan (ADL's), and had f fall Care Area Ass included R48 was	Ainimum Data Set (MDS) dated diagnoses of hip fracture, dementia. The MDS indicated ognitive impairment, required nee for all activities of daily living allen prior to admission. The essment (CAA) dated 10/16/13, at risk for falls related to poor itive deficit, care planning would e risks.					
	identified risk factor antihypertensives was included of 16 indication an orthor pressure taken wh to determine if the with position chan potential side effe	esessment dated 10/7/13, ors for falls, including use of medication, a blood pressure 56/67, however, there was no ostatic blood pressure (blood hile lying, sitting, then standing) ere was a drop in blood pressure (ges (an orthostatic change), a ct of antihypertensives o can lead to feeling dizzy or eause a fall.	9				
	R48's Progress N TABs (a personal person and sound	otes dated 10/7/13, indicated a alarm system that attaches to a ls when they attempt to get up) had been initiated to alert staff			Facility ID: 00643 If continu	ation sheet I	Page 91 of 120

	IMENT OF HEALTH	AND HUMAN	SERVICES					FORM	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/S	UPPLIER/CLIA ION NUMBER:			E CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		24:	5375	B. WING			•	12/2	20/2013
NAME OF I	PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STAT			
OTEDI IN	IG PARK HEALTH CA	RF CENTER				2 NORTH FIRST STREET			
STEREIN					VV	AITE PARK, MN 56387		NI I	(VE)
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFIC YMUST BE PRECEI SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	(PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULI) BE	(X5) COMPLETION DATE
F 323	Continued From pa when R48 attempts R48's care plan dat is at risk for falls r/t cognitive loss with i incont [incontinent], analgesia use, and directed staff to ens keep bed in low pos "Review information determine cause of remove any potenti resident/family/care care plan included a directed staff to, "G medications as ord such as orthostatic pressure of more th change] and increa and effectiveness. medical practitioner [signs or symptoms Headache, visual p disorientation, letha irritability, seizure a (Dyspnea)." An undated Nursing staff to leave walke checks, and keep b height. R48's Resident Inci at 11:25 a.m. indica	inge 91 a to get up on h ted, 10/24/13, i [related to] his impaired decisi , new to enviror osteoporosis." sure call light w sition, anticipat a on past falls a falls. Docume falls. Docume a focus of hyper ered. Observe hypotension [a nan 20 points w sed heart rate Observe/docu r PRN [as need b] of malignant roblems, confu argy, nausea ar ctivity, difficulty g Assistant Car r in place, perfo bed at appropria	er own. ncluded, "[R48] tory of, ion making, nment, daily ' The care plan vas in reach, e needs, and to, and attempt to ent. Alter ssible. Educate auses." The ertension and ensive a for side effects a drop in blood vith position (Tachycardia) ment/report to ded] any s/sx hypertension: usion, nd vomiting, v breathing e Plan, directed orm 15 minute ate transfer ated 10/27/13,	F 3	23	DEFIC			
	the floor next to her (normal blood press hg [mercury]) readin 203/82 mm hg lying sitting, a standing b	bed. Her bloc sure 120/80 mr ng at the time o and 167/76 m lood pressure	od pressure m [millimeters] of the fall was im hg while reading had not				12		
RM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6U1311		Faci	lity ID: 00643	If continuation	on sheet Pa	age 92 of 120

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	MENT OF HEALTH						FORM OMB NO	: 01/10/2014 1 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/				E CONSTRUCTION		TE SURVEY MPLETED
		24	15375	B. WING _			12	/20/2013
NAME OF I	PROVIDER OR SUPPLIER	.				TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER				42 NORTH FIRST STREET VAITE PARK, MN 56387		
		TEMENT OF DEFI	CIENCIES			PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECE	EDED BY FULL	PREFIX TAG	:	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE	COMPLÉTION DATE
F 323	Continued From pa	92 ana		F 32	23			
1 020	been obtained. The	-	noints drop in					
	blood pressure whi	ch was signific	cant, along with					
	both blood pressure	e reading were	e elevated. The					
	next documented b	lood pressure	was located in					
	R48's electronic rec	cord under Pro	ogress Notes					
	dated 10/28/13, at still elevated over 1	7 hours later	The next blood					
	pressure was found	in the electro	nic record under					
	Vital Signs, dated 1	0/29/13, a day	/ later, of 144/76					
	mm hg. No further	orthostatic blo	ood pressures					
	had been recorded.	. An Incident	Investigation					
	report dated 10/27/ being used had ma							
	staff for, "At least 1							
	walkie system." Th	iere was no in	dication the					
	alarm system had b							
	despite having a de							
	Investigation also in	icluded, "Plan	to prevent					
	further falls is to lea	ive bed at app	ropriate neight					
	so resident is not tr position and to assu	ying to stand i ure walker in r	each so if			-		
	resident attempts to	aet up she is	safer," which					
	was added to the ca		,					
			X					
		dent Demented						
	R48's Resident Inci 12:00 a.m. indicated					•		
	her blood pressure							
	of the fall. R48 had							
	and complained of I					· ·		
	Assessment Flowsh	heet had been	initiated, which					
	included frequent bl							
	next 24 hours and a				'			
	reading had not bee pressure at 12:30 a							
	mmHg. In addition,							
	Flow Sheet indicate							
	head pain on 11/2/1	3, at 12:05 a.r	m. and again at					
	3:50 a.m. The next							
ORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6U1311	•	Faci	cility ID: 00643 If contin	uation sheet F	Page 93 of 120

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		AND HUMAN SERVICES & MEDICAID SERVICES	•		C		APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245375	B. WING		·	12/	20/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OTEDIN		DE CENTER			2 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA			W	AITE PARK, MN 56387		r
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	was located under record dated 11/5/1 after the fall and co 187/78 mm hg. Th medical record an o been completed, or pain had been mon physician. In additio report dated 11/2/1 was in the lowest p as directed by the o did not include if R4 reach or not. When interviewed o DON stated, a new toilet every two hou Keeping her bed at to the Nursing Assis nursing assistants of each resident), whi the 11/2/13 fall. R48's Resident Inci 12:30 a.m. indicate hit her head, and su by 4 cm hematoma under the skin) on the blood pressure at the lying and 181/84 m Assessment Flow S were completed ever 4:00 a.m. R48's blo elevated at 199/75 pressure at 12:00 a	Intervention of offering to intervention of offering to intervention of offering to its at not been added until intervention of offering to its at night had been within intervention of offering to its at night had been initiated. The proper height was added stant Care Plan (a paper carry, which directs care for ch had not been added until ident Report dated 11/8/13, at d R48 had fallen in her room, ustained a 3 centimeter (cm) (large collection of blood the back of her head. R48's hat time was 199/84 mm hg im hg sitting. A Neurological Sheet had been started and ery four hours for 24 hours. At ood pressure remained mm hg. The final blood blood i.m. on 11/9/13 was 167/72 blogical Assessment Flowsheet	F 3	323			
	noted R48's bilatera and reacted to light	al pupils were equal, round, normally until 8:00 a.m., when					
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1311		Faci	lity ID: 00643 If continuation	on sheet P	age 94 of 120

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		AND HUMAN SERVICES & MEDICAID SERVICES			C		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245375	B. WING			12/	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RE CENTER		-	AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	indicator of brain tra remain sluggish unt stopped at 12:00 a. progress note dated R48 complained of after breakfast. R4 contacted and, "Ext know if she has any with a CT scan. Fa aggressive in reside [family member] red At 2:05 p.m. anothe "Pupils are sluggish noted this prior to fa 11/8/13, at 1:40 a.m physician had been There was no evide notified of the eleva injury, or changes in were re-educated to by bed. The Incide 11/8/13, included, "I were asking resider needed to void on the educated that we sh to toilet every two h investigation failed to assisted to the toiled	sh in reaction to light (possible auma) and continued to il the neurological exams m. (24 hours after the fall). A d 11/8/13, at 11:10 a.m. noted a head ache, and had vomited 8's relative had been blained that the only way to bleeding present would be mily does not want to be ents care and at this time quests that we just monitor" r progress note indicated her, with reaction, but nurse had all." A Progress Note dated h. indicated an on call contacted about the fall. nce the physician had been ted blood pressures, head h pupil reaction to light. Staff b make sure her walker was ent Investigation report dated n discussion with staff they at every two hours if she he night shift. Staff was nould be encouraging resident	F	323		·	
	1:30 a.m. included s the foot of the bed a pressure at the time lying and 168/89 mr A Neurological Asse	dent Report dated 11/13/13, at she had fallen in her room at and hit her head. R48's blood of the fall was 214/80 mm hg n hg sitting, a 46 point drop. essment Flowsheet had been 24 hours with blood pressure					

Facility ID: 00643

If continuation sheet Page 95 of 120

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PRINTED: 01/10/2014

		AND HUMAN SERVICES			•		FORM /	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		245375	B. WING				12/2	20/2013
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STAT	E, ZIP CODE		-
STERLIN	IG PARK HEALTH CA	RE CENTER			NORTH FIRST STREET ITE PARK, MN 56387			
	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN	OF CORRECTION	1	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. PREFIX TAG	×	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	TO THE APPROPP	BE RIATE	COMPLÉTION DATE
F 323	hg, and initial comp further orthostatic k completed. R48's p sluggish throughou evidence in the me had been notified o pressures, or the s Investigation report not been within rea plan. The report in leaving walker with resident's toileting. her to toilet and if s member reproach I There was no asse drop in blood press in R48's fall, nor we added to help prev R48. R48's Nurse practif Rounds report date physical exam by t included, "I do not review, but I am no problems." The NF Assessment, "Hypo f any problems."	114/55 mm hg to 168/89 mm blaints of a head ache. No blood pressures had been bupils were recorded as at the 24 hours. There was no edical record that the physician of the elevated blood luggish pupils. The Incident t indicated R48's walker had ach as directed by the care acluded, "Re-educated staff on in reach and on approaching Educated them to encourage she refuses have another staff her and off [sic] toileting." essment to determine if the sure would be a possible cause ere there any interventions ent further falls and injury for tioner (NP) Nursing Home ed 11/22/13, included a he NP. The NP notes have weights or vital signs to ot made aware of any P also noted, under ertension, but I am not aware There was no evidence staff of the elevated blood pressures	9	23				
	at the time of the fa neurological condit 11/13/13 falls. R48's Resident Inc	essures with position changed alls, or changes in R48 tion with the 11/2, 11/8 and sident Report dated 11/24/13, a ed R48 had fallen and had			1			
DRM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID:6U13	511	Facilit	y ID: 00643	If continuatio	n sheet Pa	age 96 of 120

		AND HUMAN SERVICES & MEDICAID SERVICES					FORMA	01/10/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(SURVEY
		245375	B. WING	-			12/2	0/2013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC 42 NORTH FIRST STREET	DE		
STERLIN	G PARK HEALTH CA	RE CENTER		1	VAITE PARK, MN 56387			
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E	3E IATE	(X5) COMPLETION DATE
	complained of left h pressure at that tim mm hg sitting. A Ne Flowsheet had bee checked over the n were recorded betw 200/83 mm hg, pup non-reactive or slug was sent to the phy had noted only a bl 161/66 mm hg. Th physician had been and 200/83 mm hg or sluggish pupils F result of the fall. Th orthostatic blood pr though R48 had a h blood pressure. A l at 9:07 p.m. indicat occurred at that tim mark on her left che dated 11/24/13, ind go to the bathroom bathroom at 10:00 identify if R48's wal was at the appropri had been assisted fall. There were no interventions were a prevent further fall. R48's Resident Inci at 9:20 a.m. indicat bathroom on the to had hit her head ag [centimeter] by 4 cr	" her head and had ip soreness. R48's blood e was recorded as, 210/83 eurological Assessment in started and were periodically ext 24 hours, blood pressures veen 113/61 mm hg and oils were recorded as either ogish. A Centracare Clinic Fax sician describing the fall, but ood pressure reading of ere was no evidence the notified of the 210/83 mm hg readings, or the non-reactive 48 was experiencing as a here was no monitoring of essures during this time, even history of an orthostatic drop in Progress Note dated 11/24/13, ed the fall had actually e, and R48 had received a red eek. The Incident Investigation icated R48 was attempting to , but had been assisted to the p.m. The report failed to ker was in reach, or if the bed ate transfer height, or if she to the bathroom prior to the indication additional added or changed to help ident Report dated 12/10/13, ed R48 had been left in the liet alone and had fallen. R48 iain and received a "4 cm n reddened area to middle of sions." The Incident		323 Fa		ntinuatior	sheet Pa	age 97 of 120

			· · · · · · · · · · · · · · · · · · ·		FORMA	APPROVED 0938-0391
(X1) PROVIDER/SUPPLIER	VCLIA (X2) ML				(X3) DATE COMF	SURVEY
245375	B. WING	6			12/2	0/2013
_IER		1.		PCODE		
I CARE CENTER			PARK, MN 56387			
FNCY MUST BE PRECEDED BY F	ULL PREF		(EACH CORRECTIVE ACTION ROSS-REFERENCED TO TH	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
port indicated staff were not leaving R48 unattend se of her impulsive behav on administration record (I ddened area on her back ined until 12/15/13. Home Rounds by the phys included, "She had a min D13, without sequelae [wit also on October 28, 2013. the note included, "For tec bod pressures and weight re was no evidence the phy f the head injury sustained 13 and 11/24/13 with the position change, declining indition with change in pup ead aches as part of the sessments. Also, there was hysician was informed of the pressures following each	led on vior. MAR) with sician nor fall on hout Under chnical s are not hysician d on n blood bil as no the falls	323				
the facilities policy not to gnitively impaired resident . She had re-educated th e at the time of the fall on DON stated staff should h pritor and notify the physic pressures, drop in blood position change, declining tus, and head injuries. In DN stated the fall investiga	leave s alone he nurse cian of ations	Equilit. 100 00				
	ARE & MEDICAID SERVI (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 245375 LIER I CARE CENTER Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMAT on page 97 port indicated staff were not leaving R48 unattend se of her impulsive behav on administration record (addened area on her back ained until 12/15/13. Home Rounds by the physic included, "She had a min 013, without sequelae [wit also on October 28, 2013. the note included, "For tector ood pressures and weight re was no evidence the phy f the head injury sustained 13 and 11/24/13 with the position change, declining indition with change in pup ead aches as part of the sessments. Also, there was hysician was informed of pressures following each on 10/27, 11/2, 11/8/13, 1 ed on 12/19/13, at 2:50 p is the facilities policy not to gnitively impaired resident b. She had re-educated the e at the time of the fall on DON stated staff should ho pritor and notify the physic pressures, drop in blood position change, declining itus, and head injuries. In DN stated the fall investiga	A. BUILL 245375 A. BUILL 245375 B. WINC LIER A CARE CENTER A	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONS A. BUILDING 245375 B. WING LIER STREET A 142 NOR WAITE F A CARE CENTER ID PREFIX TAG Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG n page 97 F 323 port indicated staff were not leaving R48 unattended on se of her impulsive behavior. on administration record (MAR) widened area on her back with ained until 12/15/13. F 323 Home Rounds by the physician included, "She had a minor fall on 013, without sequelae [without also on October 28, 2013. Under the note included, "For technical ood pressures and weights are not re was no evidence the physician f the head injury sustained on 13 and 11/24/13 with the omiting, head pain, drop in blood position change, declining ndition with change in pupil ead aches as part of the seesments. Also, there was no hysician was informed of the pressures following each falls on 10/27, 11/2, 11/8/13, 11/13, ed on 12/19/13, at 2:50 p.m. the is the facilities policy not to leave gnitively impaired residents alone i. She had re-educated the nurse e at the time of the fall on DON stated staff should have onitor and notif the physician of pressures, drop in blood position change, declining tus, and head injuries. In 2N stated the fall investigations	ARE & MEDICAID SERVICES (x1) PROVIDERSUPPLEIVCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 245375 B. WING LIER STREET ADDRESS, CITY, STATE, ZII 142 NORTH FIRST STREET WAITE PARK, MN 56387 CSTATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLANOF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY D PREFIX TAG In page 97 F 323 port indicated staff were not leaving R48 unattended on se of her impulsive behavior. on administration record (MAR) didened area on her back with since until 12/15/13. F 323 Home Rounds by the physician included, "She had a minor fall on D13, without sequelae [without also on October 28, 2013. Under the note included, "For technical ood pressures and weights are not re was no evidence the physician fine had injury sustained on 13 and 11/24/13 with the position change, declining ndition with change in pupil aad aches as part of the sessments. Also, there was no hysician was informed of the pressures following each falls on 10/27, 11/2, 11/8/13, 11/13, eet on 12/19/13, at 2:50 p.m. the is the facilities policy not to leave printively impaired residents alone 1. She had re-educated the nurse e at the time of the fall on DON stated staff should have onitor and notify the physician of pressures, drop in blood position change, declining tus, and head injuries. In DN stated the fall investigations	LTH AND HUMAN SERVICES OI ARE & MEDICAID SERVICES OI (X1) PROVDERSUPPLEXCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION 1245375 B. WING LIER STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387 YSTATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE PARK, MN 56387 stated at a minor fail on OIS, without sequelae [without ise of her impulsive behavior. nn administration record (MAR) included, "She had a minor fail on OIS, without sequelae [without iso on October 28, 2013. Under the note included, "For technical ood pressures and weights are not e was no evidence the physician indicion with change in pupil aad aches as part of the sessments. Also, there was no hysician mag. informed of the pressures following each falls on 10/27, 11/2, 11/8/13, 11/13, NON Stated staff should have pointior and notify the physician of pressures, drop in blood position change, declining nuitor and notify the physician of pressures, drop in blood position change, declining into: and notify the physician of pressures following each falls on 10/27, 11/2, 11/8/13, 11/13, No She had re-educated the nurse a at the time of the fall on DON stated staff should have onitor and notify the physician of pressures, drop in blood position change, declining tuts, and head injuries. In DN stated the fall investigations	LTH AND HUMAN SERVICES FORM./ OMB NO. (X) PRODERSUPPLERCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE (X) PRODERSUPPLERCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE 245375 B. WING 12/2 LIER B. WING 12/2 ICARE CENTER B. WING 12/2 VAITE PARK, MN 56387 FORM./ A BUILDING 12/2 VAITE PARK, MN 56387 FORM./ CONSTRUET WE ATTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 12/2 IF STATEMENT OF DEFICIENCIES FORM./ OR LSC IDENTIFYING INFORMATION) ID PROVIDENTS PLAN OF CORRECTION FORM./ CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY In page 97 port indicated staff were not leaving R48 unattended on se of her impulsive behavior. included, "She had a minor fall on O13, without sequelae [without the note included, "For technical bod pressures and weights are not re was no evidence the physician for the head injury sustained on 13 and 11/2/1/3 with the sessments. Also, there was no hysician was informed of the pressures following each falls on 10/27, 11/2, 11/8/13, 11/13, ed on 12/19/13, at 2:50 p.m. the is the facilities policy not to leave position change, declining notificed, impaired residents alone is the time of the fall on DON stated staff should have initivel impaired residents alone initivel impaired residents alone possure, for pin blood possition change, declining thus, and head injuries. In DN stated the fall Investigations

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED 0938-0391
TATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		245375	B. WING			12/2	20/2013
	ROVIDER OR SUPPLIER G PARK HEALTH CA	RE CENTER	1	14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	the proper height o	ed if the the bed had been at r if the walker had been within have attempted to determine nd added interventions to aide	F	323		. ,	
	licensed practical r	n 12/19/13, at 4:47 p.m. nurse (LPN)-A stated R48 er call light and will try to ce or twice a day, attempting to n.					
	nursing assistant (transfer herself on to be left alone in t know what height	on 12/19/13, at 4:49 p.m. NA)-L stated R48 attempts to ce or twice a week. R48 is not he bathroom. NA-L did not R48's bed was suppose to be alker was suppose to be					
	stated the "girls," h Otherwise she wa R48 was in bed, th	n 12/19/13, at 5:00 p.m. R48 help her to the bathroom. s not oriented to time or place. he bed was in a low position hs across the room by the t by her bed.					
	stated R48 is not the bed is supposed would be if sitting feet should touch Nursing Assistant	on 12/19/13, at 5:05 p.m. NA-K to be left in the bathroom alone, e to be, "a little down." This on the edge of the bed, R48's the floor. After consulting the Care Plan, NA-K stated R48's within reach, and verified it was		Fa	acility ID: 00643	uation sheet I	Page 99 of 120

DEPART	MENT OF HEALTH		RVICES					FORM A	01/10/2014 PPROVED)938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION	LIER/CLIA	• •	PLE CONSTRUC G			(X3) DATE COMPI	SURVEY _ETED
		24537	5	B. WING				12/20	0/2013
NAME OF F	ROVIDER OR SUPPLIER					ESS, CITY, STATE, 2	ZIP CODE		
	G PARK HEALTH CA				142 NORTH FI				
						OVIDER'S PLAN OF	CORRECTION	4	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	(EACI	H CORRECTIVE AC -REFERENCED TO DEFICIEN	TION SHOULD THE APPROPF	BE	COMPLÉTION DATE
F 323	Continued From pa	ige 99		F 32	3				
(R48 had six falls, fr elevated blood press blood pressures with a position change, symptom, head act head injuries which informed of. The falls, ar interventions to hele An undated facility When to Report to that systolic blood p over 115 immediate 90 the next day are The form also indice physician if the resis associated with a re complications, and room immediately form further indicate with any suspected and to report routing since last visit.	ssures at the time nich dropped signi- declining neurolog nes, and vomiting the physician was cility did not comp nd consistently imp p decrease her ris policy of Change i the MD/NP/PA for pressures over 21 ely, and diastolic ro a reported to the pl sated the need to c ident sustained a c to send to the em for a fall with no c to send to the em for a fall with head ed to report immed	of the falls, ficantly with ical following s not rehensively olement k for falls. n Condition, m identified 0, diastolic outinely over hysician. contact the contusion other ergency injury. The diately falls y hip pain,				• • • • • • •		
	The immediate jeop at 6:00 p.m., was re p.m. when the facil reassessment of R who had a fall withi appropriate interve were re-educated p regarding specific f correct implementa plans were updated frequent checks an for all resident with	emoved on 12/20/ ity completed a fal 42, R38 and other in the past 6 month ntions were in plac prior to beginning v fall interventions to ation of the care plac d, and implementa id monitoring were identified falls, bu	13 at 2:00 Is residents ns to ensure ce; all staff vork ensure an, care tion of completed t				footing	shoot Door	- 100 of 120
DRM CMS-25	67(02-99) Previous Versions		Event ID:6U1311		Facility ID: 00643	I	f continuation	aneer mage	

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	IMENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245375	B. WING			12/:	20/2013
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
OTEDI IN	IG PARK HEALTH CA	RECENTER			142 NORTH FIRST STREET		
SIERLIN	IG PARK HEALIN CA			\	WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5). COMPLETION DATE
F 323	noncompliance rem and severity level, o immediate jeopardy R11's had multiple f compressively reas appropriate interver risk of falls. R11's current annua indicated she was r needed extensive a ambulation. The MI since prior assessm frequently incontine admission Care Are 10/16/13 indicated s and fell 30 days prio (water pill), frequent had a history of freq intentional position of R11's falls assessm she received diureti fluid), inadequate vi urine, had loss of ba requires hand on as to place, had falls 3 assessment summa and disorientated w falls in addition to in R11's bladder asses indicated she was fr requires assist with received diuretics. she showed most co hours and sporadic	ained at an isolated scope of actual harm that was not factual harm that was not sessed, to determine ntions to help decrease the al MDS dated 10/16/13, noderately cognitively intact, issistance with transfers, and DS indicated R11 had no falls nent of 10/9/13 and was int of bladder. R11's a Assessment (CAA) dated she had a potential for falls for to admit, was on a diuretic tly incontinent of urine and quent falls in addition to changes. nent dated 10/10/13, indicated cs (medication to decrease sion, frequently incontinent of alance while standing, isistance to move from place 0 days prior to admit. The ary indicated she was alert ith a recent history of frequent tentional position changes. issment dated 10/10/13, requently incontinent of urine, ambulation and transfers, The assessment indicated continence during waking incontinence at night, she did	F	323			
		incontinence at night, she did our toileting and they are					

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Facility ID: 00643

If continuation sheet Page 101 of 120

PRINTED: 01/10/2014

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM. MB NO.	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245375	B. WING		12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RECENTER	V	VAITE PARK, MN 56387	! 	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	assisting her to the staff returning 10 m R11's current care she was at modera unaware of safety n loss, gait/balance p with incontinence. toilet R11 every thr minutes if refuses y transfers and toilet fall mat, pressure-s tabs (personal safe R11's nursing assis indicated R11 had bed, floor mat next anti rollbacks on w and to toilet every 3 hours at night and check if needing to During observation was observed in her wheelchair with tab During observation was asleep in her to position with a sen R11 was observed sitting in her room attached to her wh Review of R11's Re from 7/23/13 to 11/ four falls were relat care plan as follow The incident report a.m. R11 was foun her bed. The falls had not toileted R1 checked R11 every she needs to use to	toilet every two hours with ninutes later and as needed. plan dated 10/13/13, indicated te risk for falls related to needs, short term memory problems and bladder urgency The care plan direct staff to ee hours and return after 10 with assistance of one for ing. R11 had a low bed with a sensor pad in her bed, and a sty) alarm in her chair. stant care plan (undated) a sensor pad in her bed, low to bed, non-slip in wheelchair, heelchair, alarm on wheelchair 8 hours during the day and 2 to return in 10 minutes and toilet again. 12/16/13, at 5:30 p.m. R11 er room , sitting in her os (personal alarm) attached. on 12/18/13, at 7:03 a.m. R11 bed which was in the low sor alarm on. on 12/19/13, at 10:30 a.m. next to her desk, with alarm eelchair. esident Incident Reports dated 24/13 identified multiple falls, ted to staff not following R11's	F 323			

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Event ID: 6U1311

Facility ID: 00643

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If continuation sheet Page 102 of 120

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	N	245375	B. WING			12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET VAITE PARK, MN 56387		
			ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLÉTION DATE
F 323	Continued From pa		F	323			
	did not follow the ca re-educated.	are plan and were					
	R11 was found on t fall investigation inc toileted at 2:00 a.m nursing assistant s a.m. but did not go	identified 9/30/13, at 4:45 a.m. floor mat next to her bed. The dicated resident had last been , and during interview with he checked her pad at 4:00 back and check to see if she toilet. Staff did not follow the re-educated.					
	a.m. R11 was found was left alone on the minutes later on the	identified on 11/4/13, at 5:00 d on the floor in her room. R11 he commode and was found 10 e floor. Staff did not follow the e educated not to leave d on the commode.					
	at 6:20 a.m. R11 w her bed, sitting on 1 toileted at 2:45 a.m on rounds at 4:00 a was on and she wa the commode post getting up to use th re-educated about	report identified on 11/24/13 as found on the floor next to the floor mat. R11 had been and denied need for toileting a.m. The resident's call light is incontinent of urine but used fall. R11 stated she was the toilet. Staff were appropriate call light response lan as identified by the care					
	early morning hour was no indication the reassessed R11 fat interventions to hel	our falls in her room during the s, form 2:00-6:00 a.m. there he facility had compressively lls, to determine appropriate p decrease her risk of falls on of the staff involved with					

If continuation sheet Page 103 of 120

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DEPART		AND HUMAN SERVICES					FORMA	01/10/2014 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SUR COMPLETE	
		245375	B. WING				12/2	0/2013
	PROVIDER OR SUPPLIER	RE CENTER		1.	TREET ADDRESS, CITY, STATE 42 NORTH FIRST STREET VAITE PARK, MN 56387	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD) BE	(X5) COMPLETION DATE
F 323	occupational therap aware R11 had falls re-evaluate R11 but falls were isolated a necessary. The fall OT-A, and stated the during the night shi staff reassess R11 update her toileting OT-A further stated alone on the comm During interview 12 stated R11's bladde has sporadic incom toileting every 1.5 h not improved. RN- falls during the nigh had not reassesse patterns with incom During interview 12 verified the falls we R11's care plan on The DON stated sh unable to recall wh determine if it was The DON further si should have been attempt to reduce I R66 falls were not determine appropri decrease risk of fall R66 care plan upda diagnoses of hyper	2/19/13, at 9:03 a.m. with bist (OT)-A stated she was a and had offered to t was informed by staff the and didn't feel it was Its were reviewed with the he falls were related to toileting ift. OT-A would recommend the bladder incontinence and times more frequently. The t that R11 should not be left hode. 2/19/13, at 10:00a.m. RN-A er assessment indicated she tinence at night and had tried hours but her continence had A verified R11 had multiple ht shift related to toileting and d her toileting plan looking for tinence and her falls. 2/19/13, at 10:30a.m. the DON ere related to staff not following the night shift with toileting. he educated the staff but was ich staff were re-educated to a pattern of a certain staff. tated R11's toileting plan reassessed and updated in R11's falls.		323				
)RM CMS-2	unspecified anxiety	v state. The 14-day Minimum s Obsolete Event ID:6U131	1	Fa	cility ID: 00643	If continuatio	n sheet Pa	ge 104 of 120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SU	E SURVEY PLETED 20/2013 (X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET	(X5)
NAME OF PROVIDER OR SOFFLIER 142 NORTH FIRST STREET	
STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 56387	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 323 Continued From page 104 Data Set (MDS), dated 12/11/2013, indicated R66 had moderately impaired cognition, and required extensive assistance for transferring, walking in the room, and use of the toilet. The MDS also indicated R60's balance was not steady, and was only able to stabilize with staff assistance. The functional abilities care area assessment (CAA), dated 12/10/2013, indicated R66 required extensive assistance with activities of daily living (ADL) related to a recent hospitalization and change in cognition. The urinary continence CAA indicated R66 needed assistance for toileting. A facility fall risk assessment, dated 11/27/2013 indicated R66 was at high risk for falls, required extensive assist of 2 for transfers, was unable to stand at this point, required weight-bearing support, needed reminers of use of the call light, and that R66 had a history of falls while living in his apartment with his wife. The assessment indicated staff were to monitor attempts to self transfer, and use of the call light. R66's individual temporary care plan, dated 11/27/13, identified the problem of safety, and indicated that R66 "has history of falls, requires extensive assist. Monitor for attempts to self-transfer and use of call light. Has a walker to assist with transfers." A Resident Incident Report, dated 12/11/2013, indicated R66 had a fail on 12/22/2013 at 8.05 a.m., was found lying on left side in his bathroom, had no injury and denied hitting his head. The Fall Investigation report, dated 12/11/2013, indicated R66 had a fail on 12/22/2013 at 8.05 a.m., was found lying on left side in his bathroom, had no injury and denied hitting his head. The Fall Investigation report, dated 12/11/2013, indicated R66 had a fail on 12/22/2013 at 8.05 a.m., was found lying on left side in his bathroom, had no injury and denied hitting his head. The Fall Investigation report, dated 12/11/2013, indicated R66 had a nunvitnessed fail, and R66 was unable to tell staff what he was d	

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Facility ID: 00643

If continuation sheet Page 105 of 120

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PRINTED: 01/10/2014

DEPARTMENT (F HEALTH	AND HUMAN SERVICES			OMB NO.	APPROVED 0938-0391
CENTERS FOR ATEMENT OF DEFICE ND PLAN OF CORRECT	ENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245375	B. WING			0/2013
NAME OF PROVIDER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		(X5) COMPLETION DATE
During nursing limited (ADLs) NA-By stated in the bathro said R weight progree During license cognit asked to be I that ". have a assign alone During LPN-I alone During LPN-I alone During the ce "Was had s The 0 "May In an direct R66's felt R fall, a need were for R alone	g assistant (assistance , and was a vas certain the care pla bathroom, b om because 66 requires bearing as ss" since ac an intervie ad practical fon "fluctuat how it was eft alone in [R66] does a TABS alar ed, then he " LPN-A sa S alarm. g an intervie g at intervie g at intervie g at intervie g at intervie g at intervie g at intervie or of nursin fall inciden 66's bradyc nd suggest s seated." T added to th	v on 12/19/2013 at 12:11 p.m., NA)-B stated R66 required with activities of daily living able to express his needs. R66 could use a call light, and an indicated he can be left alone out "I just stay with him in the e he is so quick." NA-B also help with transfers and needs sistance, and has "really made dmission to the facility. w on 12/19/2013 at 9:10 a.m., nurse (LPN)-A stated R66's es", and "has dementia". When determined if it was ok for R66 the bathroom, LPN-A stated as self transfer, and if he would m [brand name safety alarm] a would not be safe to leave id right now he "does not have" w on 12/19/2013 at 8:50 a.m., how if R66 was safe to be left toom. w on 12/19/2013 at 8:59 a.m., e practitioner (CNP) stated R66, in familiar places recently", and mptoms of increasing dementia. that R66 has bradycardia, which for falls." n 12/19/2013 at 2:45 p.m., the g (DON) said she responded to t of 12/11/13 and R66's doctor ardia was the root cause of the ed R66 complete, "All toileting the DON said that intervention e nursing assistant care sheets oN felt R66 was safe to be left room, but verified the facility did	1		inuation sheet F	Page 106 of 120

EPARK INCN OF UNLER & MEDICARE & MEDICALD SERVICES 021 MULTIPLE CONSTRUCTION 021 MULTIPLE CONSTRUCT			AND HUMAN SERVICES			0	FORM A	APPROVED 0938-0391
De FLAN OF CORRECTION 243375 B. WING 12/20/2013 AME OF PROVIDER OR SUPPLIER STRELING PARK HEALTH CARE CENTER STRELING PARK HEALTH CARE CENTER SUMMARY STATEMENT OF DEPERTING INFORMATION (PACH OF PROVIDER OR SUPPLIER) TAG SUMMARY STATEMENT OF DEPERTING INFORMATION (PACH OF PROVIDER OF CONTENT OF DEPERTING INFORMATION) PRETX WATER PARK, MN 58367 Continued From page 106 (pach content of the APROPRIATE Detriction or not. Even though R66 had a history of falls prior to admission, brady cardia, needed assistance with transferring and had increased confusions, he was left alone in the bathroom and fell. The facility identified as their fail policy and procedure which instructed. "A comprehensive fail risk assessment consists of: The Fail risk analysis: This coleckils reviews the resident shistry of fails, internal and external risk factors for fails, internal and external risk factors for failing. Risk factors for fail and injury reduction. Each identified as ashould trigger an intervention		S FOR MEDICARE				CONSTRUCTION	(X3) DATE	SURVEY
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTT, SINEL BODGE STERLING PARK HEALTH CARE CENTER 14 2007H PROST STREET VAID SUMMARY STREMENT OF DEFICIENCIES PROST VAID SUMMARY STREMENT OF DEFICIENCIES PROST PARK HEALTH CARE CENTER 12 SUMMARY STREMENT OF DEFICIENCIES PROST VAID SUMMARY STREMENT OF DEFICIENCIES PROST CONTINUEST E PRECEDED BY FULL PROST RESULATORY OR LSC IDENTIFYING INFORMATION PROST CONSERVERTER DEFICIENCIES DEFICIENCIES F323 Continued From page 106 F323 F323 F323 F323 F323 F actility and had increased confusions, he take a system in place to determine a newly admitted resident could be left alone in the bathroom and fell. The facility did not comprehensively assess Re6 fail fisk factors for land in the abatroom and fell. The facility did not comprehensively add procedure within the factors including; assessment consists of. The sketts history of fails, internal and external fisk analysis: This checklist reviews the resident shet yor fails, internal and external risk factors for failing. Risk factors for failing. Risk factors for failing. Risk factors for fail and injury reduction. Each leftled are should frigger an inference. If the resident fails developing an appropriate plan of care for fail and injury reduction. Each leftled are should frigger an inference is nearboard field. The resident fails developing an appropriate plan of care for fail and injury reduction. Each leftl	D PLAN OF	D PLAN OF CORRECTION					12/2	20/2013
STERLING PARK HEALTH CARE CENTER WAITE PARK, MN 56337 (M) D FREETX TAG SUMMARY STETMENT OF DEFICIENCES (CONSTRECTION STORMEDT OF DEFICIENCES) (FOR CONSTRECTION STORMEDT REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG D PRETX CONTINUED FOR CONSTRECTION STORMEDT (CONSTRECTION STORME					STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CMUD TAG SUMANCESTICIENT OF DEPICIPACIES (CRUENCES) MUST BE RECEEDED BY FULL (CRUENCES) PIETR TAG CECH CORRECTION SHOULD BE CRUENCES TO THE APPROPRIATE COMBATION (CRUENCES) F 323 Continued From page 106 not have a system in place to determine if a newly admitted resident could be left alone in the bathroom or not. Even though R66 had a history of falls prior to admission, brady cardia, needed assistance with transferring and had increased confusions, he was left alone in the bathroom and fell. The facility provided a document titled Comprehensive Pall Risk Guidelines dated G2010 which the facility identified as their fall policy and procedure which instructed, "A comprehensive fall risk assessment consists of. The Fall risk nalysis: This checklist reviews the residents history of falls, Internal and extrant risk factors including; sensory impairments, medical conditions, medications, physical function impairments, behaviors and environmental risk factors for regulated to assist in developing an appropriate plan of care for fall and injury reduction. Each identified area should trigger an intervention. The resident risk areas consistent with specific conditions, the care plan effects efforts to seek alternatives to address the needs identified Afall risk analysis is required after any fall invort of the facility. The completed incident report, falls risk analysis, and internal investigation are reviewed by members of the interdisciplinary feam (UT) after any fallThe administrator and nursing services are prosponsible to ensure the facility adhress to the transmitter structure						AITE PARK, MN 56387		(X5)
F 323 Continued From page 106 not have a system in place to determine if a newly admitted resident could be left alone in the bathroom or not. Even through R66 had a history of falls prior to admission, brady cardia, needed assistance with transferring and had increased contisions, he was left alone in the bathroom and fell. The facility did not comprehensively assess R66 fall risk to determine appropriate interventions to decrease risk of falls. The facility provided a document titled Comprehensive Fall Risk Guidelines and Fall Prevention Guidelines dated 6/2010 which the facility identified as their fall policy and procedure which instructed, "A comprehensive fall risk assessment consists of. The Fall risk ranalysis: This checklist reviews the residents history of falls, internal and external risk factors including; sensory impairments, medical conditions, medications, physical function impairments, behaviors and entified area should trigger an intervention. The resident plan of care which identifies; the fall history. The resident sikk arease consistent with specific conditions, needs, behaviors, and preferences. If the resident refuses or resists interventions, the care plan refices efforts to seek alternatives to address the needs identified A fall risk ranalysis is required after any fall involut of the facilityThe completed incident report, falls risk analysis, are quired after any fall involut of the facilityThe completed incident report, falls risk analysis, are quired after any fall involut of the facilityThe completed incident report, falls risk analysis, are quired after any fall involut of the facilityThe completed incident report, falls risk analysis, are quired after any fall involut of the facilityThe completed incident report, falls risk analysis, are guired after any fall involut of the facilityThe completed incident report, falls risk analysis, are guired after any fall involut of the facilityThe completed incident report, falls risk analysis, are responsible to ensur	(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	PREF		(EACH CORRECTIVE ACTION SHOULD		COMPLETION
needs identified A fall risk analysis is required after any fall in/out of the facilityThe completed incident report, falls risk analysis, and internal investigation are reviewed by members of the Interdisciplinary Team (IDT) after any fallThe administrator and nursing services are responsible to ensure the facility adheres to the		Continued From p not have a system admitted resident bathroom or not. Even though R66 admission, brady transferring and h was left alone in t facility did not corr risk to determine decrease risk of f The facility provic Comprehensive F Prevention Guide facility identified a which instructed, assessment cons This checklist rev falls, internal and sensory impairm medications, phy behaviors and et falling. Risk fact injury are also id appropriate plan reduction. Each intervention Th identifies; the fa areas consisten behaviors, and p	age 106 in place to determine if a newly could be left alone in the had a history of falls prior to cardia, needed assistance with ad increased confusions, he he bathroom and fell. The nprehensively assess R66 fall appropriate interventions to alls. led a document titled Fall Risk Guidelines and Fall lines dated 6/2010 which the as their fall policy and procedure "A comprehensive fall risk sists of: The Fall risk analysis: views the residents history of a external risk factors including; ents, medical conditions, vironmental risk factors for ors for increased potential for entified to assist in developing a of care for fall and injury identified area should trigger and the resident plan of care which Il history. The residents risk t with specific conditions, needs preferences. If the resident ts interventions, the care plan a coak alternatives to address til	an n n	323			
Event ID: 6U1311 Facility ID: 00643 H Contribution of the Contribu		needs identified after any fall in/ incident report, investigation ar Interdisciplinary	I A fail risk analysis is required out of the facilityThe complete falls risk analysis, and internal e reviewed by members of the r Team (IDT) after any fallThe nd nursing services are ensure the facility adheres to the	d		Facility ID: 00643 If continu	uation shee	et Page 107 of 1

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	01/10/2014 APPROVED 0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	PLETED
		245375	B. WING	i		12/2	0/2013
	ROVIDER OR SUPPLIER			14:	REET ADDRESS, CITY, STATE, ZIP CODE 2 NORTH FIRST STREET AITE PARK, MN 56387		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE
F 323 F 353 SS=E	to determine wheth preventable and/or Department of hea State Regulations. falls is the most im Appropriate preven initiated at admissi care plan and the sheet. Consider P review by pharmar Assistive devices foot wear, lap bud skid products for s bars on wheelchai such as helmets, alarms, fall mats, booster pillows, et toileting needs, in monitor the fall log have been logged is documented in the nursing assist fall Nursing service monitoring falls for activity to determine and necessary suc 483.30(a) SUFFIC PER CARE PLAN The facility must h provide nursing a maintain the high and psychosocial determined by rea- individual plans of	bolicy and procedure including her the accident/ incident was reportable to the MM alth according to Federal and Interventions: A history of portant predictor of future falls. ntion measures should be ion. List all interventions on the nursing assistant assignment PT/OT assessment. Medication cist. Environmental review. such as a seat belt, change of dy, anti roll back devices, non seating and floors, and anti tip irs, etc. Protective devices hip protectors, chair/ bed high/low beds, floor mats, ic. Additional monitoring for fections, drug reactionsmust g routinely to assure that all falls and an appropriate intervention the fall log, on the care plan and ant assignment sheet for each vice is responsible for r patterns of time, locations and ne appropriate staffing levels ipervision." CIENT 24-HR NURSING STAFF NS have sufficient nursing staff to nd related services to attain or est practicable physical, mental, well-being of each resident, as sident assessments and f care. provide services by sufficient	F	323	agreement by the facility of of the facts alleged or com- set forth in the statement of deficiencies. The plan of prepared for this deficienc executed solely because p of state and federal law re Without waiving the forego statement, the facility state respect to:	ency does not be on nor an if the truth clusions of correction y was provisions quire it. bing es with	Page 108 of 12

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			FORM A OMB NO.	APPROVED 0938-0391
DENTERS FOR MEDICARE	& MEDICAID SERVICES			(X3) DATE	SURVEY
CENTERS FOR MEDIO A: TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		PLETED
	245375	B. WING			20/2013
	245575	L	STREET ADDRESS, CITY, STATE, ZIP CC	DE	
NAME OF PROVIDER OR SUPPLIER			142 NORTH FIRST STREET	•	
STERLING PARK HEALTH CA	RE CENTER		WAITE PARK, MN 56387	RECTION	(X5) COMPLETION
	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION		DATE
 personnel on a 24- care to all resident care plans: Except when waiv section, licensed r personnel. Except when waiv section, the facility nurse to serve as duty. This REQUIREM by: Based on observe review, the facility patterns were sur assistance to me residents (R51, F R24 and R25) in with and/or ident staffing. Findings includee R51 had to wait assisted with inoc caused her disco R51's annual Mi 10/8/13, include (paralysis of all intact, showed v one to three day required extens activities of daily 	f the following types of hour basis to provide nursing in accordance with resident ed under paragraph (c) of this nurses and other nursing red under paragraph (c) of this y must designate a licensed a charge nurse on each tour of ENT is not met as evidenced vation, interview and document / failed to ensure staffing fficient to provide timely et resident needs, for 9 of 41 R9, R6, R18, R12, R20, R13, the facility who were identified ffied in concerns of insufficient long periods of time to be ontinent pad changes, which		 353 1. Call light report will for each day for one. 2. Audits will be condeach call light revise that sufficient staffibuilding and to revipatterns. This audresident interview. 3. The data collected presented to the G by the ED/DNS. The collected will be reviewed/discussed quarterly QA meetime the QA Commake the decision/recommeregarding any foll. Completion date: January 2 	will be to assure ing present in iew for it will include will be the data ed at the ting. At this mittee will endation ow-up studies.	

PRINTED: 01/10/2014
FORM APPROVED
OMB NO 0938-0391

EPAR II FNTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			CONSTRUCTION	(X3) DATI	0938-0391
TEMENT (TATA PROVIDER/SUPPLIER/OLIA					COMPLETED	
		245375	B. WING				20/2013
	ROVIDER OR SUPPLIER		•	142	REET ADDRESS, CITY, STATE, ZIP CODE NORTH FIRST STREET		
ERLIN	G PARK HEALTH CA			WA	AITE PARK, MN 56387 PROVIDER'S PLAN OF CORREC	TION	(X5)
X4) ID REFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
F 353	Continued From pa incontinent of bow	el and bladder.	F	353			
ļ	R51 stated she off periods of time, so she needed assist stated she was pa anything for herse always rushed, the makes me feel ba	on 12/17/13, at 11:00 a.m. en had to wait for extended ometimes up to one hour, when cance with something. R51 iralyzed and unable to do lf. She added, "The aides are ey say they are working short, it d for needing so much help."					
	a.m. R51 stated s took so long for so She indicated sor hour. R51 stated after supper, and morning. R51 stated short staffed, and feel bad they are	b interview on 12/19/13, at 10:00 the became upset because it omeone to answer her call light, netimes the wait was up to an the longest wait times were then after midnight until ated, "The aides say they are I they rush through helping me, short, but I have to wait to get a get my pad changed." R51 the	I n		·		
	stated, "Now I kn diaper is wet." R out when she had reported that holl	ow why a baby cries when their 51 stated she began to "holler" d to wait a long time. She ering out was more effective to but she then was told she had to se the staff were working short.)				
	12/18/13, revealed activated for ove during the month times were betw	gs from 11/18/13, through ed her call light had been r 25 minutes, on 18 occasions n long period. All of the wait een 5:55 p.m. and 12:15 a.m. 11 p.m. her call light wait was on 12/8/13, at 7:02 p.m. her call as 58.5 minutes.					
	R51's care plan at high risk for p	dated 10/9/13, indicated she wa ressure ulcers related to	is		acility ID: 00643 If cont	in the sheet	t Page 110 of

		AND HUMAN SERVICES				PRINTED: 0 FORM AI OMB NO. 0	PPROVED
DEPART	MENT OF HEALTH	AND HUMAN SERVICES			۱ <u>ــــــــــــــــــــــــــــــــــــ</u>	(X3) DATE S	
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE (CONSTRUCTION	COMPL	ETED
AND PLAN C	F CORRECTION		B. WING			12/20	0/2013
		245375	B. WING	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			142	NORTH FIRST STREET		
STERLIN	NG PARK HEALTH CA			WA	NTE PARK, MN 56387 PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
F 353	incontinence and o cares. The care p behavior problems assistance after sh care plan directed as appropriate." When interviewed director of nursing light times as app complained of exo times, she would there were any lo staff to see why th from this, the DO attempts to correct had not checked despite having be expressed conce R9 reported she insufficient staffin employee interview stated R9 requires assistance with b During interview stated she did not morning due to shad happened to few months. R9 bath but I am affin	dependence upon staff for lan also indicated she had is related to calling out for ne turned on her call light. The staff to, "Monitor call light times on 12/19/13, at 8:30 a.m. the (DON) explained, "Monitor call ropriate," meant if R51 cessive call light response review the call light logs. If ng wait times she checked with ne waits were so long. Aside N verified she had not made ct the long call light times. She these call light logs recently, een aware that R51 has rns about long waits. did not receive her bath due to ng, which was corroborated by ews. DS dated 10/4/13, included ciety and depression. The MDS uired supervision and set up	is	353			
FORM CM	1S-2567(02-99) Previous Vers	sions Obsolete Event ID:6U	1311	F	acility ID: 00643 If cont	tinuation sheet	Page III 0112

PRINTED: 01/10/2014 FORM APPROVED OMB NO: 0938-0391

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	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. (0938-0391
JEPARTI SENTER	S FOR MEDICARE	& MEDICAID SERVICES		IPLE CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG		LETED
		245375	B. WING _			0/2013
				STREET ADDRESS, CITY, STAT	E, ZIP CODE	
	ROVIDER OR SUPPLIER			142 NORTH FIRST STREET WAITE PARK, MN 56387		
STERLIN	G PARK HEALTH CA				LOF CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE IENCY)	DATE
F 353	Continued From p	age 111	F 3	353		
	stated R9 missed short staffing. NA offered later in the she preferred to b R6 stated the faci provide timely ass	n 12/19/13, at 11:30 a.m. NA-B her bath last Saturday do to -B added that a bath was e day, but R9 refused because bathe in the morning. lity did not have enough staff to sistance for toileting.				
	resident had no c totally dependent eating.	DS dated 10/15/13, identified the ognitive impairment and was on staff for all ADLs except				
	resident stated sl assisted to the ba bathroom in her l an hour at times assistance. R6 r time seemed to b R6 stated she ha	on 12/16/13, at 4:20 p.m. the he had to wait "so long" to be athroom that she had to go to the brief. R6 stated it had been over that she had to wait to receive reported the evening after suppo be the longest response times. ad complained "many times" to wait to be assisted to the tated, "I hate sitting in my poop				
	stated that one of call light had been one had gone in that although sh evening, she fin resident to the k no one had help	on 12/17/13, at 8:20 p.m. NA-L evening, several weeks prior, Re en on for over 45 minutes but no to help her. NA-L then stated he was not assigned to R6 that ally went and assisted the bathroom because she felt "bad bed her for such a long period of ore NA-L stated she had not ne else regarding this concern.				
	The facility did resident counci	not respond appropriately to I concerns related to sufficient		Facility ID: 00643	If continuation sheet	Page 112 of 1

EPART	MENT OF HEALTH	AND HUMAN SERVICES				(X3) DATE	0938-0391 SURVEY
ENTER	S FOR MEDICARE	& MEDIOARD CERVELA	(X2) MUL	TIPLE CO	DNSTRUCTION	` ́сом	PLETED
ATEMENT (OF DEFICIENCIES	(X1) PROVIDENCE IN THE INFORMATION NUMBER:	A. BUILDI	NG			
U PLAN OF	John Letter		B. WING			12/	20/2013
		245375	B. WING	STRF	ET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			142 1	NORTH FIRST STREET		
				WAI	TE PARK, MN 56387		
STERLIN	G PARK HEALTH CA		ID		THE PLAN OF CORRECT	ION I D BE	(X5) COMPLETION
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC DEENTIEYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
PREFIX	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
TAG	REGOD (COM)						
			F	353			
F 353	Continued From p	age 112	-		•		
	مر سال ا	and by resident council mooting					
					,		
	members for 7 of	41 residents (ICIO, ICIE, Inded					
	R13, R6, R24 and	cil meetings. Refer to F244 for					
	additional informa	ation.					
	1						
	There was 1 of 3	family members (FM)-J					
		complaints the facility did not ff to answer calls lights timely.					
	have enough stat	Tto answer bane ngine v					
	During interview	on 12/16/13, at 4:30 p.m. FM-J					
	stated she visited	the facility daily and the facility					-
	seemed to "alwa	ys" be short staffed. She stated	4				
	to the facility bell	ng short staffed. I m o ceeks ago	5				
			e				
	l i i leasformill	mamper was able to ton other					
		ed to go to the bathroom; ten had to wait for so long to be					
	hated rolated	to short staning that one in the					
	assisted related	nd have to sit in it.					
	-						
	There was 4 of	7 nursing assistants (NA-C,	re				
		A-L, NA-D) that complained the ent staffing to complete there wo	rk				
	was not sufficie	ent staning to complete allere are					
	timely.						
	During interview	w on 12/17/13, at 8:10 p.m. NA-	N				
			ie				
			.m.				
	it took "a while	to answer call lighter view short					
1	NA-N stated th	tated the staff does their best to					eet Page 113

PRINTED:	01/10/2014
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		AND HUMAN SERVICES				OMB NO. 0938-0391	
DEPARIN		& MEDICAID SERVICES				(X3) DATE SURVEY COMPLETED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	12/20/2013	
		245375	B. WING				
				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			142	2 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	ARE CENTER		W	AITE PARK, MN 56387 PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
F 353	Continued From p provide the neces and it can take a l especially on the stated if there were done on the even often could not be not enough staff. During interview of stated the evenin staffed. She stat complained of lor answered, but th At 8:50 p.m. NA- had been short of months," but mo NA-L stated the facility did not ha either they had t who had already mandated to stat During an interv NA-C stated ger more staff," as t times during that there were time which "could ha availability. NA- resident, R16, r toilet." NA-C stated for	age 113 sary cares for the residents, ong time to answer call lights, East side of the building. NA-N re extra cares that needed to be ing shift, such as baths, those completed because there was on 12/17/13, at 8:20 p.m. NA-L g shift was "always" short ed she knew residents ing waits to have their call light e NAs did the best they could. L stated staffing at the facility in all shifts in the last "few re so during the evening shifts. Schedule was posted and the ive enough NAs for the shift, so o work short staffed or someone worked eight to ten hours was y, which was not very helpful. iew on 12/19/13, at 8:49 a.m., hereally, "[The] p.m. shift could us here seemed to be long call light is that resident falls occurred, ve been avoided" with more stat C said she recalled that a ecently had a fall, a "fall from that did she was working that day an nother resident when she noted t off. She stated, "After [R16] fer	se t ff e d	353			
	During an inter NA-F stated sh staff, especially "very rushed."	view on 12/19/13, at 12:37 p.m., e did not think there was enoug y on the evening shift which was NA-F stated she was unable to	5		Facility ID: 00643 If co	ntinuation shee	et Page 114 of

EPARTMENT OF HEALTH A	(X3) DATE COM	(X3) DATE SURVEY COMPLETED				
D PLAN OF CORRECTION				12/	12/20/2013	
	245375	B. WING	STREET ADDRESS, CITY, STATE			
AME OF PROVIDER OR SUPPLIER			142 NORTH FIRST STREET			
TERLING PARK HEALTH CAR	RECENTER		WAITE PARK, MN 56387			
SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREFIX TAG		O THE APPROPRIATE	(X5) COMPLETION DATE	
TAG REGULATORY OR L	(EACH DEFICIENCY MUST BE FREDEDED OT REGULATORY OR LSC IDENTIFYING INFORMATION)			,		
but I do not leave u never am out by 8 know what others o	nti all cares are done so l p.m." She added, "I don't lo."	F3	353			
 NA-D stated, "Som staff, with our care There are a lot of c [shifts]. It gets frus "Baths can get pus We will not give so week their second someone who gets 483.30(e) POSTE INFORMATION The facility must p a daily basis: o Facility name. o The current date o The total number by the following c unlicensed nursin resident care per - Registered nursin resident censed provocational nurses - Certified nur o Resident censul The facility must part of the facility must part of the facility must part of the facility must part of the following c unlicensed nursin resident care per - Registered nursin resident care per - Registered nursin resident censul for the facility must part of the facility must par	er and the actual nours worked ategories of licensed and g staff directly responsible for shift: nurses. actical nurses or licensed s (as defined under State law). rse aides. us. post the nurse staffing data on a daily basis at the beginning ata must be posted as follows: lable format. place readily accessible to	F	F356 356 The preparation of th of correction for this not constitute and s interpreted as an ac agreement by the fa of the facts alleged set forth in the state deficiencies. The p prepared for this de executed solely be of state and federa Without waiving th statement, the fact respect to:	hould not be Imission nor an acility of the truth or conclusions ement of blan of correction eficiency was cause provisions al law require it. e foregoing		

	NT OF HEALTH	AND HUMAN SERVICES			FORM / OMB NO.	APPROVED 0938-0391_
ENTERS I	FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	
		245375	B. WING			20/2013
	VIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 142 NORTH FIRST STREET WAITE PARK, MN 56387		
X4) ID REFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			(X5) COMPLETION DATE
F 356 C Th fo st fo fo st f f f f f f f f f f f f f f f f f f	ontinued From pa he facility must, up hake nurse staffing or review at a cost tandard. The facility must m taffing data for a r equired by State la This REQUIREME Based on observa- eview, the facility nformation for nur he beginning of ea o affect all 41 resi all visitors. Findings include: During initial tour of facility staff postin- on a bulletin board. Although the nam census were inclu- number of license hours worked wer For the 6:00 a.m. indicated there we (LPNs) and four n posting did not lis During interview of director of nursing posting was in he bulletin board. Th of hours worked werked werked		s s r	 356 4. Medical Records of will create posting, post daily 5. Audits will be done weeks, than week months 6. The data collected presented to the O by the ED/DNS. To collected will be reviewed/discussed quarterly QA meet time the QA Commake the decision/recommergarding any foll Completion date: February 	a daily for 2 by for two a will be by Committee The data ed at the ting. At this mittee will endation ow-up studies	1/24/14 Del addende

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		A MEDICAID SERVICES	·	. 0	MB NC). 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245375	B. WING		12	/20/2013
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	120/2013
STERLI	NG PARK HEALTH CA	RE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BF	(X5) COMPLETION DATE
F 356	Continued From page	ge 116	F 356	3		~ .
F 441 SS=D	but not provided. 483.65 INFECTION SPREAD, LINENS	e staff posting was requested CONTROL, PREVENT	F 441	F 441		
	Infection Control Prosafe, sanitary and control help prevent the control of disease and infection Control The facility must estate Program under which (1) Investigates, comin the facility; (2) Decides what prosahould be applied to (3) Maintains a recorractions related to infe	Program ablish an Infection Control h it - trols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections.		The preparation of the following p of correction for this deficiency do not constitute and should not be interpreted as an admission nor a agreement by the facility of the tru of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provision of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	oes an uth s on	
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact wi direct contact will tran (3) The facility must n	n Control Program ident needs isolation to infection, the facility must prohibit employees with a se or infected skin lesions th residents or their food, if ismit the disease. equire staff to wash their ct resident contact for which ated by accepted		 Nursing staff education to be completed on proper hand washing and gloving procedures by January 24 2014 The DNS and/or her designee will complete 5 audits per week for one month than 3 audits a wee for two months on random staff. 	k	
().						

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 117 of 120

PRINTED: 01/10/2014 FORM APPROVED

STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245375	B. WING	An an an an an an an an an an an an an an		10010010
STERL	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 142 NORTH FIRST STREET WAITE PARK, MN 56387	IP CODE	2/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Personnel must han	ge 117 dle, store, process and is to prevent the spread of	F 4	41		
	by: Based on observation review, the facility fail infection after staff p resident (R16), and t to providing assistan	T is not met as evidenced on, interview, and document led to minimize the spread of rovided personal cares for a hen did not wash hands prior ce for a compromised 1 of 9 observations of		3. The data colle presented to th Committee by The data colled reviewed/discu quarterly QA m this time the Q will make the decision/recom regarding any f studies.	the DNS. cted will be issed at the neeting. At A Committee	
	nursing assistant (NA morning cares for R1 NA-D groomed R16's washed R16's face w partially dressed R16. with perineal care, an the soiled gloves. NA- with NA-C, transferred NA-D neither washed nor used an alcohol-b	6 in the resident's room. hair, performed oral cares, ith warm wash cloth, and Next, NA-D provided R16 d removed and disposed D then dressed R16, and, d R16 to a wheel chair. hands with soap and water, ased hand sanitizer at any hile performing cares or		Completion date: Januar	y 24, 2014	
	room and immediately answer the resident's wash hands prior to er had contact precautior					

Facility ID: 00643

DEPART		AND HUMAN SERVICES & MEDICAID SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245375	B. WING		·	12/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET		
STERLIN	G PARK HEALTH CA	RECENTER	~	-	AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	sanitizer after provi when leaving the re- R47's diagnoses, a Minimum Data Set included quadripleg pressure ulcers (pa involving epidermis had pressure ulcers also indicated R47 indwelling, suprapu dependent upon sta record identified R4 bacterial infection, i were being impleme In an interview on 1 acknowledged after R16 she did not wa sanitizer prior to en assistance. NA-D s did not even realize "I should have was! into another room. I R47 "had C-diff" an in place for R47 rela NA-D stated she ha when hired, and "we especially about ha During an interview the director of nursi wash their hands be with residents. The inservices throughof the facility complete hands are washed	A-D did not wash hands or use ding assistance to R47 or esidents room at 8:39 a.m. s indicated from the admission (MDS) dated 7/17/2013, jia, presence of Stage 2 rtial thickness skin loss , dermis, or both. R47 also s and pneumonia. The MDS was cognitively intact, had an bic catheter, and was totally aff to meet daily needs. The 7 had Clostridium difficile, a n which contact precautions ented. 2/18/13, at 9:02 a.m. NA-D r providing perineal care to sh her hands or use a hand tering R47's room to provide tated "I just got so into it," and a I did not wash my hands and hed my hands" before going NA-D stated she was aware d "special precautions" were ated to the C-diff infection. ad infection control training e get reminders often,	F 4	41			
							go 119 of 120

Facility ID: 00643

If continuation sheet Page 119 of 120

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PRINTED: 01/10/2014

CENTERS FOR MEDICARE	AND HUMAN SERVICES				INTED: 0' FORMAP 1B NO. 09	
ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		X3) DATE SI COMPLE	JRVEY
	245375	B. WING			12/20/	2013
AME OF PROVIDER OR SUPPLIER	RECENTER		STREET ADDRESS, CITY, STATE 142 NORTH FIRST STREET WAITE PARK, MN 56387	, ZIP CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B O THE APPROPRI		(X5) DMPLETION DATE
	ng safe, resident care."	F 44	11			
director of nursing (infection control nur "should be washing for a resident, and p and beginning cares especially to preven "compromised" resid ADON verified R47 antibiotic treatment, also said routine and providing resident ca	2/19/13, at 8:12 a.m. assistant ADON), also the facility se, stated nurses and staff hands" after doing peri-cares rior to entering another room for a different resident, t transmission to any dent, such as R47. The was currently receiving and "had C-diff." The ADON d frequent handwashing after ares was "reviewed and ecially with the aides."					
The facility Handwas dated 1/10, directed to use alcohol-based	shing Policy and Procedure, staff when it was appropriate I hand sanitizers, and when nds with soap and water.					
				·		
CMS-2567(02-99) Previous Versions Ob	solete Event ID: 6U1311	Fa	cility ID: 00643	continuation she	et Page 12	0 of 120
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		AND HUMAN SERVICES & MEDICAID SERVICES	F	5275012	FORM	: 01/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION NG 02 - 2010 ADDTION	(X3) DAT COM	TE SURVEY MPLETED
		245375	B. WING		12	/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE PRIATE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K O	00		
	Fire Safety:			,		
1-39-14	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		POC 04 TS 1-30-14		
jer.	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.	-			
EUT: 12 70-13	Minnesota Departm Fire Marshal Division Sterling Park Health substantial complian participation in Med Subpart 483.70(a), 2000 edition of Nate Association (NFPA) Code (LSC), Chapter PLEASE RETURN	R THE FIRE SAFETY TAGS) TO: RE INSPECTIONS SHAL DIVISION ET, SUITE 145		RECEIVED JAN 2 9 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	 NATURE	TITLE		(X6) DATE
. 2	A St		Vecut	the Director	1.	714
Any deficient	cy statement ending with		and the second se	titution may be excused from correcting providi	ng it is det	ermined that

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES **ВЕРАКТМЕИТ ОF НЕАLTH AND HUMAN SERVICES**

PRINTED: 01/10/2014 FORM APPROVED OMB NO. 0938-0391

t Page 2 of 6	ation shee	ility ID: 00643 If continu	Гас		Event ID: 6U1321	Opsolete	snoisaev suoiveaq (99-20)78	es-emo мяо=
; ;	es not erpreted in the plan of ciency ciency it. it.	K 050 K 050	< 020		DN FOR EACH W: DE ALL OF THE been, or will be, done completion date. The person d monitoring to the deficiency. the building the deficiency. the building the deficiency. the building the deficiency. the building the deficiency. the deficiency. the building the deficiency. the deficiency. the deficiency. the building the deficiency. the defi	RRECTIC T INCLU RMATIO RMATIO RMATIO RMATIO RECTIC RMATIO RECTIC RMATIO	to correct the deficie 2. The actual, or pro- responsible for corre- responsible for corre- responsible for corre- responsible for corre- responsible for corre- the construction dat the construction dat story addition withou was constructed in 5 be of Type II(111) co story addition withou facility has a fire ala detection in the corre- the time of the surve department of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve the time of the surve	Here and the second sec
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(X5) COMPLETION DATE	BE	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	∀G EEIX D	ВЧ	YING INFORMETION) PRECEDED BY FULL = DEFICIENCIES	I BE TRUM	(EACH DEFICIENCY	01 (X4) ХІТЭЯЧ ЭАТ
	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387		71		ЯЗ	КЕ СЕИТ	ис рекк неагтн са	
£102/6	1/21		_	B. WI	542375			
PLETED SURVEY	TAD (£X) MOD	E CONSTRUCTION 01-2010 ADDTION			VIDER/SUPPLIER/CLIA TIFICATION NUMBER:		DE COBRECTION . OF DEFICIENCIES	

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - 2010 ADDTION	(X3) DATE SURV COMPLETE	
		245375	B. WING			12/19/2013	
	PROVIDER OR SUPPLIER	RE CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH FIRST STREET AITE PARK, MN 56387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 050	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between announcement may alarms. 18.7.1.2 This STANDARD is Based on review of interview, it was de to conduct 4 of 12 m by the NFPA 101 Li 18.7.1.2. This defice staff react in the ev by staff would affect visitors and staff. Findings include: On facility tour betw 12/19/2013, during available fire drill re and interview with t (JC), it was reveale conduct 2 fire drills	ge 2 at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: f reports, records and termined that the facility failed equired fire drills as required fe Safety Code (00) section cient practice could affect how ent of a fire. Improper reaction t the safety of all 40 residents, yeen 9:00 AM and 1:00 PM on a documentation review of the ports for the last 12 months he Director of Maintenance d that the facility failed to in the second quarter, and 2 quarter of the calendar year.	K	050	 As of 8/28/2013, the Director Maintenance has completed the according to fire and life safety of We have preformed a drill on all We have completed and will con complete these drills on a regula and in accordance with fire and safety code. ED or designee will preform m audits for three months, that the are being done and documented correctly according to fire and life code. The data collected will be reviewed/discussed at the month meeting. At this time the QA committee will make the decision/recommendation regard any follow-up studies and require audits Completion date: January 24, 20 K 052 The preparation of the following correction for this deficiency doe constitute and should not be into as an admission nor an agreem 	drills sode. shifts. tinue to ir basis life nonthly drills e safety hly QA ling ed 14 14	
K 052 SS=F	of Maintenance (JC	ce was verified by the Director) FETY CODE STANDARD	к	052	the facility of the truth of the fac alleged or conclusions set forth statement of deficiencies. The correction prepared for this defi	ts in the plan of	ia:

Event ID: 6U1321

Facility ID: 00643

If continuation sheet Page 3 of 6

PRINTED: 01/10/2014 FORM APPROVED MB NO, 0938-0391

9 to 14 age 4 of 6	tinuation shee	ty ID: 00643 If con	Facili		Event ID: 6U1321	etelosdO) anoianaV auoivanq (99-20)∑8	-OBM CMS-25
	sao	The preparation of the following I of correction for this deficiency d not constitute and should not be interpreted as an admission nor		КC		(This deficient practio of Maintenance (JC) NFPA 101 LIFE SAF	ЗЗ=Е К 005
	thly QA rding red	documented correctly accord fire and life safety code. 3. The data collected will be reviewed/discussed at the mon meeting. At this time the QA decision/recommendation rega any follow-up studies and requi audits Completion date: January 24, 2 audits Completion date: January 24, 2 202			 7.1. These ely affect the em that could emergency 1 and 1:00 PM on ation review of the alarm 2 Director of tion for the last tion for the last 	Z2, Sections ould adverse e alarm syst fication and y thus negat y thus negat sorts and fire oorts and fire documenta view with the t was reveale t was reveale t was reveale	Well as 1999 NFPA. deficient practices c functioning of the fir delay the timely noti actions for the tacilit residents, staff, and 72/19/2013, during a available fire drill rep maintenance/testing maintenance/testing failed to document a failed to document a	
	pue 'sy u	regular basis and in accordance fire and life safety code. 2. ED or designee will preform monthly audits for three mont that the drills are being done that the drills are being done			interview, the ain the fire alarm equirements of	thets bns noi anism bns lit n ent the n	This STANDARD is Based on observati facility failed to insta system in accordand 2000 NFPA 101, Se	
	r of le drills all will rode.	Without waiving the foregoing statement, the facility states with to: Maintenance has completed th according to fire and life safety We have preformed a drill on a We have preformed a drill on a scontinue to complete these dril continue to complete these dril	290	к	I Code and NFPA d maintenance with applicable	d maintained an approve gronglying gronglying	Continued From pag installed, tested, and with UFPA 70 Vation X2. The system has and testing program requirements of UFI	K 025
(X5) COMPLETION DATE	ULD BE	РЕОСИДЕК'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		ח אפר דאס	CEDED BA ENTE		ATS YAAMMUS YOFH DEFICIENCY YAOTAJUƏJA	PREFIX PREFIX TAG
		2 NORTH FIRST STREET 2 NORTH FIRST STREET 2 NN 56387	14			ВЕ СЕИТЕ	ю ракк неагтн са	
19/2013	TREET ADDRESS, CITY, STATE, ZIP CODE			B. WING				I AME OF I
ורנדנם פטגעבע		соияткиол NOITODA 0102 - 2			AIJOVAPLIER/CLIA ATION NUNER:		DE COBRECTION . OF DEFICIENCIES	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 02 - 2010 ADDTION	(X3) DATE SUF COMPLET		
		245375	B. WING		12	/19/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	IG PARK HEALTH CA			142 NORTH FIRST STREET			
SIERCI	IG FARR ILALIII OA			WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			
K 062 K 144 SS=F	Required automatic continuously mainta condition and are in periodically. 18.7.6 9.7.5 This STANDARD is Based on documer with staff, the facility and maintain the au accordance with NF section 18.7.6, 4.6.1 does not ensure tha functioning properly event of a fire and or residents, staff and Findings include: On facility tour betw 12/19/2013, a revie interview with the D revealed the facility documentation for 3 sprinkler flow tests 13(99) and NFPA 25 This deficient practio of Maintenance (JC NFPA 101 LIFE SAL	 sprinkler systems are ained in reliable operating spected and tested a, 4.6.12, NFPA 13, NFPA 25, a not met as evidenced by: Intation review and interview and interview and interview and static sprinkler system in FPA 101 Life Safety Code (00) 12. This deficient practice at the fire sprinkler system is and is fully operational in the could negatively affect all 40 visitors. a veen 9:00 AM and 1:00 PM on w of documentation and irector of Maintenance (JC), failed to provide 3 out of the last 4 quarterly fire inspections required by NFPA 5(98). ce was verified by the Director) ETTY CODE STANDARD pected weekly and exercised inutes per month in 	K 062	 of the facts alleged or conclusiset forth in the statement of deficiencies. The plan of corresprepared for this deficiency we executed solely because provide of state and federal law require Without waiving the foregoing statement, the facility states we respect to: 1. As of 8/28/2013, the Directed Maintenance has completed to flow test according to fire and safety code We have complete tests on a quarterrly basis in accordance with fire and life side code. 2. ED or designee will preform quarterly audits for three quart that the tests are being done a documented correctly according fire and life safety code. 3. The data collected will be reviewed/discussed at the month meeting. At this time the QA committee will make the decision/recommendation regard any follow-up studies and require audits 	ions ection as isions e it. ith or of ne life ted hese afety ers, ind ig to hly QA		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00643

If continuation sheet Page 5 of 6

PRINTED: 01/10/2014 FORM APPROVED (X3) DATE SURVEY (X3) DATE SURVEY

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	14	Completion date: January 24, 20						
	run sion b b b b c c c c c c c c c c c c c c c	 interpreted as an admission for a signation for a signation of the facts alleged or conclusion of the facts alleged or conclusion deficiency was deficiencies. The plan of correct was externely because provision deficiency was expected solely because provision deficiency was expected. A sole of of this deficiency was expected to the facility states and tederal law required to the facility states and tederal law required to the solely because provision of state and test once a month waiving the facility states are being do to the correctly according to the data collected will be the dot of the data collected will be the dot of the data collected will be the dot of the data collected will be the dot in the test once at the month of the test once of the month of the facts collected will be the dot in the test once of the data collected will be the dot in the test once of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of the month of the test once of test once of test once of test once of the test once of test onc			to test the emergency with the requirements ety Code section 9.1.3 (a) & (b) and 6-4.2.2. Id affect all 40 "s. "s. "ng logs indicated that ing logs indicated that "12 weekly	v failed dance dance ite saf o 6-4.2 ce coul or testi onthy or testi onthy or testi onduc ronthy or testi on tom onthy or testi on or testi on or testi on or testi on or testi on or testi or or br>or testi or or or or or or or or or or or or or	Based on documer interview, the facility generators in accor of 2000 NFPA 110 and 1999 NFPA 110 The deficient practio residents, staff, and findings include: On facility tour betw findents, staff, and inspections and 3 n emergency generat emergency generat inspections and 3 n emergency generat	
	nsian	The preparation of the following p of correction for this deficiency do not constitute and should not be	144	КЧ		g əb	eq moi∃ b∋unitno⊃	K 144
		K 144						
COMPLETION DATE (X5)	BE	PEFICIENCY (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF CROSS-REFERENCED TO THE APPROPF		DI PAEFI DAT	ITEYING INFORMATION) SE PRECEDED BY FULL OF DEFICIENCIES	a teum '	(EACH DEFICIENCY	(X4) ID PREFIX TAG
ГREET ADDRESS, СІТУ, ЗТАТЕ, ZIP CODE 12 ИОRTH FIRST STREET /AITE PARK, MN 56387			71		ИТЕК	RE CEI	יפסעוסבא סא פטרפרובא אסעוסבא אבאבאר כא כם אנגע אבאבאר א	
19/2013	121		-	B. WING	545375			
		9						
Ε 206ΛΕΛ		E CONSTRUCTION 52 - 2010 ADDTION			SOVIDER/SUPPLIER/CLIA		DE COBRECTION . OF DEFICIENCIES	
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If continuation sheet Page 6 of 6

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6U1321

Facility ID: 00643

		AND HUMAN SERVICES & MEDICAID SERVICES		F6375023	FORM	: 01/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245375	B. WING			/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STERLIN	G PARK HEALTH CA	RE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
TAG				DEFICIENCY)		
K 000	INITIAL COMMENT	TS	- ĸ	000		
	Fire Safety:			l k		
	THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		POC ok KSS WIAW for KSS WIAW 1-30-14	э	
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		R 1-30		
8	Minnesota Departm Fire Marshal Division Sterling Park Healt substantial complian participation in Mec Subpart 483.70(a), 2000 edition of Nat Association (NFPA	Survey was conducted by the nent Of Public Safety, State on. At the time of this survey, hcare Center was found not in nce with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety ter 19 Existing Health Care.		RECEIVED	1	
	DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO: RE INSPECTIONS		JAN 2 9 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
	STATE FIRE MARS 444 CEDAR STRE ST. PAUL, MN 551	ET, SUITE 145 01-5145, or		7. —		
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG			,	(X6) DATE
H	ALAN	-	+Yel	stitution may be excused from correcting pro		
other safegu following the	ards provide sufficient pro date of survey whether of	otection to the patients. (See instruction or not a plan of correction is provided.	ns.) Exce For nursir	ept for nursing homes, the findings stated abor ng homes, the above findings and plans of co cies are cited, an approved plan of correction	ove are disclos prrection are di	sable 90 days isclosable 14

program participation.

		AND HUMAN SERVICES				M APPROVEI 0. 0938-0391	
				LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245375	B. WING		1.	2/19/2013	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE 142 NORTH FIRST STREET WAITE PARK, MN 56387	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa By e-mail to: Marian.Whitney@s	-	ĸ	000			
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.			hecer.	ED		
	 The actual, or pro The name and/or responsible for corr 	oposed, completion date.					
	the construction dat existing building (bluwith a partial basem constructed at 3 diffibuilding was constru- be of Type II(000) c addition was added determined to be of 2003 an addition was determined to be of plans for this 2003 a 1985 Life Safety Co building and the 2 a	rveyed as two buildings due to tes of the buildings. The dg #1) is a 1 story building nent. The building was ferent times. The original ucted in 1963, it determined to construction. In 1983, an to the dining room that was "Type II(000) construction. In as added to the east that was "Type II(111) construction. The addition were reviewed to the ode. Because the original additions meet the construction kisting buildings, the facility ne building.					
	facility has a fire ala detection in the corr corridors that is mo	sprinklered throughout. The arm system with smoke ridors and spaces open to the nitored for automatic fire tion. The facility has a					

		AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
	245375		B. WING			12/19/2013	
	AME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER				14	12 NORTH FIRST STREET		
	OTAKI MEALIN VA			W	AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
8					K 050	- C	
K 000	Continued From pa	-	- K	000	The presention of the following pla	an of	
	licensed capacity o the time of the surv	f 60 and had a census of 40 at ey.			The preparation of the following pla correction for this deficiency does constitute and should not be interp	not reted	
	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:				as an admission nor an agreement the facility of the truth of the facts		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are			050	alleged or conclusions set forth in statement of deficiencies. The pla	n of	
001					correction prepared for this deficie was executed solely because prov	ncy isions	
					of state and federal law require it. Without waiving the foregoing	asnert	
£					statement, the facility states with r to:	sapeor	
	qualified to exercise	e leadership. Where drills are			1. As of 8/28/2013, the Director of Maintenance has completed the d	rills	
		9 PM and 6 AM a coded y be used instead of audible			according to fire and life safety co	de.	
	alarms. 19.7.1.2				We have preformed a drill on all s	nifts.	
					We have completed and will conti complete these drills on a regular	basis	
					and in accordance with fire and lif	e	
		s not met as evidenced by:			safety code.		
		f reports, records and termined that the facility failed			2. ED or designee will preform mo	onthly	
		required fire drills as required			audits for three months, that the d	rills	
	by the NFPA 101 Li	fe Safety Code (00) section			are being done and documented	cofety	
		cient practice could affect how ent of a fire. Improper reaction			correctly according to fire and life code.	Salety	
		t the safety of all 40 residents,					
	visitors and staff.				The data collected will be reviewed/discussed at the monthl		
	Findings include:				meeting. At this time the QA committee will make the	y G (7) F	
	On facility tour betv	On facility tour between 9:00 AM and 1:00 PM on			decision/recommendation regard	ng	
	12/19/2013, during	a documentation review of the			any follow-up studies and require	d	
		ports for the last 12 months			audits		
		he Director of Maintenance to that the facility failed to				4	
		in the second quarter, and 2					
					Completion date: January 24, 20	17	

Event ID: 6U1321

Facility ID: 00643

If continuation sheet Page 3 of 8

		AND HUMAN SERVICES			FORM	01/10/2014 APPROVED
STATEMENT	AND PLAN OF CODDECTION DEPARTICULATION NUMBER.			E CONSTRUCTION 01 - MAIN BUILDING 01	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		245375	B. WING		12/19/2013	
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		DE CENTER	14	42 NORTH FIRST STREET		
STERLIN	IG PARK HEALTH CA	RECENTER	N	VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
				K 052		
K 050	Continued From pa	ge 3	K 050	The properties of the full	20	
		quarter of the calendar year.		The preparation of the following p correction for this deficiency does constitute and should not be inter as an admission nor an agreemen	not preted	
		ice was verified by the Director		the facility of the truth of the facts	пгру	
K 052 SS=F	of Maintenance (JC NFPA 101 LIFE SA	,) FETY CODE STANDARD	K 052	alleged or conclusions set forth in statement of deficiencies. The pla	the an of	
	installed, tested, an	required for life safety is d maintained in accordance nal Electrical Code and NFPA		correction prepared for this deficie was executed solely because pro of state and federal law require it.	ency visions	
	72. The system has and testing program	n complying with applicable PA 70 and 72. 9.6.1.4		Without waiving the foregoing statement, the facility states with r to:	respect	
		÷		1. As of 8/28/2013, the Director of Maintenance has completed the according to fire and life safety of We have preformed a drill on all shifts. We have completed and w continue to complete these drills regular basis and in accordance fire and life safety code.	drills ode. /ill on a	
	Based on observation facility failed to instance system in accordance 2000 NFPA 101, Se well as 1999 NFPA deficient practices of	s not met as evidenced by: ion and staff interview, the all and maintain the fire alarm ice with the requirements of ections 19.3.4.1 and 9.6, as 72, Sections 7.1. These could adversely affect the		2. ED or designee will preform monthly audits for three months, that the drills are being done and documented correctly according fire and life safety code.	d b	
	delay the timely not actions for the facili	re alarm system that could ification and emergency ty thus negatively affecting all and visitors of the facility.		 The data collected will be reviewed/discussed at the monthly meeting. At this time the QA committee will make the 		
	Findings include:			decision/recommendation regardin any follow-up studies and required	g	
		veen 9:00 AM and 1:00 PM on a documentation review of the		audits		
		aliter and the second second second second second second second second second second second second second second		Completion date: January 24, 2014	4 _	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6U1321	Fac	sility ID: 00643 If continu	ation shee	et Page 4 of 8

			0		APPROVED 0938-0391
OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
	245375	B. WING		12/1	9/2013
ROVIDER OR SUPPLIER					
G PARK HEALTH CA	RECENTER				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
available fire drill re maintenance/testing 12 months and inter Maintenance (JC), i failed to document a tests of the fire alar This deficient practi of Maintenance (JC	ports and fire alarm g documentation for the last rview with the Director of it was revealed that the facility and/or verify 4 of 12 monthly m DACT.	K 052 K 055		<u>p</u> w	2
window or outside on nurseries and room less than 24 hours. This STANDARD is Based on observat courtyard was enclor of the courtyard an resident rooms, cre of the resident room window and does n NFPA Life Safety C section 19.3.8 This 1 of 40 residents, si without exterior win Findings Include: On facility tour betwon 12/19/2013, it was of EAT does not have	toor, except for newborn is intended for occupancy for 19.3.8 is not met as evidenced by: tion and interview, an exterior osed in 2010. The enclosing d the recent remodeling of a ated a condition such that one his no longer has an outside ot meet the requirements of ode 101 (00) Chapter 19 deficient practice could affect taff and visitors, in the area dows.		Waiver attached		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa available fire drill re maintenance/testing 12 months and inten Maintenance (JC), if failed to document a tests of the fire alar This deficient praction of Maintenance (JC) NFPA 101 LIFE SA Every patient sleep window or outside of nurseries and room less than 24 hours. This STANDARD is Based on observation courtyard was enclored of the courtyard and resident rooms, cree of the resident room window and does no NFPA Life Safety C section 19.3.8 This 1 of 40 residents, s without exterior win Findings Include: On facility tour betwo 12/19/2013, it was of reason for this deficient Part of the resident have reason for this deficient for the section the section 1 of the section the sect	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and interview with the Director of Maintenance (JC), it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the fire alarm DACT. This deficient practice was verified by the Director of Maintenance (JC) NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation and interview, an exterior courtyard was enclosed in 2010. The enclosing of the courtyard and the recent remodeling of a resident rooms, created a condition such that one of the resident rooms no longer has an outside window and does not meet the requirements of NFPA Life Safety Code 101 (00) Chapter 19 section 19.3.8 This deficient practice could affect 1 of 40 residents, staff and visitors, in the area without exterior windows.	Image: Construct of a supprise of the construction of the construction of the resident rooms in tended for occupancy for less than 24 hours. Image: Construction of the construction	INVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRECIDENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO THE ADDRESS (EACH ORRECTION SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO SHOULD CROSS-REFRENCED TO THE ADDRESS (EACH ORRECTIVE ACTION SHOULD TO CROSS-REFRENCED TO THE ADDRESS (EACH ORRECTIVE ACTION CROSS-REFRENCED TO THE ADDRESS (EACH ORRECTIVE ACTION CROSS-REFRENCED TO THE DIRECTOR OF Maintenance (JC), NFPA 101 LIFE SAFETY CODE STANDARD EVERY patient sleeping room has an outside window and outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 K 055 This STANDARD Is not met as evidenced by: Based on observation and interview, an exterior countyard was enclosed in 2010. The enclosing of the countyard and the recent remodeling of a resident rooms, created a condition such that one of the resident rooms, created a condition such that one of the resident rooms, created a condition such that one of the resident, staff and visitors, in the area without exterior windows. Findings Include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, it was observed that resident room EMP does not	GVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET SPARK HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 4 available fire drill reports and fire alarm maintenance(JC), it was revealed that the facility failed to document and for verify 4 of 12 monthly tests of the fire alarm DACT. K 052 This deficient practice was verified by the Director of Maintenance (JC) NFPA 101 LIFE SAFETY CODE STANDARD K 055 Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation and interview, an exterior courtyard was enclosed in 2010. The enclosing of the courtyard and the recent remodeling of a resident rooms no longer has an outside window and does not meet the requirements of NFPA LIFE Stafety Code 11 (00) Chapter 19 section 19.3.8 This deficient practice could affect 1 of 40 residents, staff and visitors, in the area without exterior windows. Windows. Findings Include: Con facility tour between 9:00 AM and 1:00 PM on 12/19/2013, it was observed that resident room CH7 does not have a window to the exterior. The reason for this deficient condition is from the

If continuation sheet Page 5 of 8

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pl		01/10/2014 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245375	B. WING			12/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA	RE CENTER			42 NORTH FIRST STREET NAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 055	Continued From pa	ae 5	ĸ)55	K 062		
К 062 SS=F	addition and remodeling project. During an interview with the Director of Maintenance (JC), room Aris not occupied/utilized by a resident at the time of the survey and that it is in the planing stages to be converted from a resident room into a storage room. This deficient practice was verified by the Director of Maintenance (JC)			062	The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the t of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correc prepared for this deficiency was	loes an ruth ns tion ons t. n	
	Based on documer with staff, the facility and maintain the au accordance with NF section 19.7.6, 4.6.1 does not ensure tha functioning properly event of a fire and or residents, staff and Findings include: On facility tour betw 12/19/2013, a review interview with the D revealed the facility documentation for 3	reen 9:00 AM and 1:00 PM on w of documentation and irector of Maintenance (JC),			 and will continue to complete and will continue to complete the tests on a quarterrly basis in accordance with fire and life safe code. 2. ED or designee will preform quarterly audits for three quarter that the tests are being done and documented correctly according fire and life safety code. 3. The data collected will be reviewed/discussed at the monthly meeting. At this time the QA committee will make the decision/recommendation regardin any follow-up studies and required audits 	d ese ety s, d to ⁷ QA	
	67(02.00) Providuo Versiona						

Facility ID: 00643

If continuation sheet Page 6 of 8

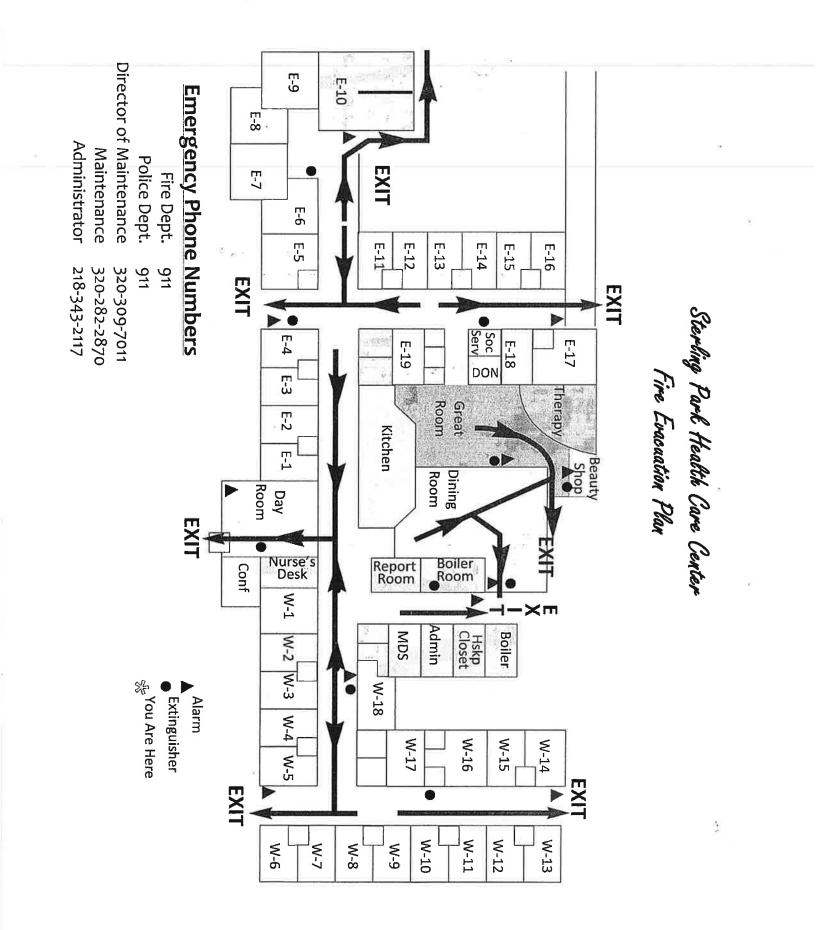
and the second s		AND HUMAN SERVICES				FORM	01/10/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				E SURVEY IPLETED
		245375	B. WING			12/19/2013	
	PROVIDER OR SUPPLIER	RE CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From pa 13(99) and NFPA 2	-	-κ K	062	Completion date: January 24, 201	4	
K 144 SS=F	of Maintenance (JC NFPA 101 LIFE SA Generators are insu under load for 30 m accordance with NF This STANDARD is Based on documer interview, the facility generators in accor of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 40 m Findings include: On facility tour betw 12/19/2013, docum emergency generat the facility failed to inspections and 3 m	FETY CODE STANDARD bected weekly and exercised binutes per month in FPA 99. 3.4.4.1. s not met as evidenced by: ntation review and staff y failed to test the emergency dance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents, staff, and visitors.	K	144	K 144 The preparation of the following of correction for this deficiency of not constitute and should not be interpreted as an admission nor agreement by the facility of the to of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correct prepared for this deficiency was executed solely because provisi of state and federal law require Without waiving the foregoing statement, the facility states with respect to:	loes an ruth ns tion tion ons it.	

Facility ID: 00643

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES			RINTED: 01/10/2 FORM APPRO MB NO, 0938-0	VED
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245375	B. WING		12/19/2013	3
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	G PARK HEALTH CA			142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET	TION
K 144		ice was verified by the Director	K 144	 As of 9/14/2013 the Director Maintenance completed the required load test once a mor according to fire and life safet code. 	nth	
				2. ED or designee will preform monthly audits for three mont that the load test are being do and documented correctly acc to fire and life safety code.	hs, one	
	r			3. The data collected will be presented to the QA Committed the ED. The data collected w reviewed/discussed at the mod QA meeting. At this time the Committee will make the decision/recommendation reg any follow-up studies amd rec audits.	ill be onthly QA arding	21
				Completion date: January 24, 2	014	
^				.05		
FORM ONE OF	67(02-99) Previous Versions	Obsolete Event ID:6U1321		acility ID: 00643 If continu	uation sheet Page 8	0.010

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