MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6U13
Facility ID: 00643

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245375**
2. STATE VENDOR OR MEDICAID NO. (L2) **502490100**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **3/4/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **53** (L18)
13. Total Certified Beds **53** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Tim Rhonemus, HFE NE II 3/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 3/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **02/15/2014** (L33)

DETERMINATION APPROVAL

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,

Kate Johnston

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,

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245375	A. Building B. Wing	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 ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0157	483.10(b)(11)		01/24/2014
F0164	483.10(e), 483.75(l)(4)		01/24/2014
F0166	483.10(f)(2)		01/24/2014
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)		01/24/2014
F0226	483.13(c)		01/24/2014
F0244	483.15(c)(6)		01/24/2014
F0248	483.15(f)(1)		01/24/2014
F0282	483.20(k)(3)(ii)		01/24/2014
F0309	483.25		01/24/2014
F0314	483.25(c)		01/24/2014
F0323	483.25(h)		01/24/2014
F0353	483.30(a)		01/24/2014
F0356	483.30(e)		01/24/2014
F0441	483.65		01/24/2014

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	3/11/2014	20794	3/4/2014
CMS RO				

Followup to Survey Completed on: 12/20/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00643	A. Building B. Wing	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	**01/24/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**01/24/2014**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	**01/24/2014**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**01/24/2014**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp. 4** LSC	**01/24/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	**01/24/2014**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	**01/24/2014**	ID Prefix **21435** Reg. # **MN Rule 4658.0900 Subp. 1** LSC	**01/24/2014**	ID Prefix **21855** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	**01/24/2014**
ID Prefix **21880** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	**01/24/2014**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	**01/24/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	**01/24/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	3/11/2014	20794	3/4/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/20/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245375	A. Building 02 - 2010 ADDTION B. Wing	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) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/24/2014	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 01/24/2014	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 01/24/2014
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/24/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	3/11/2014	27200	2/19/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2013			

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,

Brenda Fischer

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

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

ID: 6U13

Facility ID: 00643

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/20/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **60** (L18)

13. Total Certified Beds **60** (L17)

10. THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B ,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NE II 01/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

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. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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:

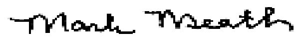
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, 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

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.

2/22/13

[illegible]

RECEIVED

FEB 11 2013

MN Dept of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents, (R16) who self administered medications, was assessed for safe self administration of an inhalation medication. Findings include: R16 had diagnosis of a fractured left femur and was admitted to the facility for rehabilitation services. The minimum data set (MDS) dated 11/8/12, indicated R16 was cognitively intact but had impaired vision. During observation and resident interview on	F 176	2/22/13 See addendum to POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 2.7.13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 1/8/13 at 4:44 p.m. R16 stated her inhaler was reported as missing personal property. An inhaler was observed on the resident's bedside nightstand. R16 indicated that after the inhaler went missing, her husband brought another one from home. R16's physician orders dated 10/26/12 included "Albuterol 90 MCG (microgram)/actuation sol inhalation-PRN as needed. May have inhaler at bedside." R16's medical record revealed an assessment for self administration of Nebulizer treatment, however there was no assessment or care plan provision for self administration of the inhaler medication. Review of the medication administration record (MAR) indicated R16 received the inhaler 1 time on December 4, 2012 and had no record of receiving the inhaler from January 1-11, 2013. When interviewed on 1/11/13 at 8:45 a.m., the assistant director of nursing (ADON) stated they did assess R16 for the Nebulizer treatment but not for the inhaler that was kept at bedside. She further stated that R16 had not been given a MAR to record if she used the inhaler per the facility self administration of medications policy. When interviewed on 1/11/13 at 10:00 a.m., R16 stated she usually uses her inhaler two times per day or less, "some days I don't use it at all if my breathing is OK". R16 stated she never was given a sheet to record if she took the inhaler or not. Even though the physician had ordered for R16 to	F 176	F 176 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Residents # 16 has had a self administration of medication assessment completed. Care plan has been updated. Resident #16 has also been provided a MAR to record how often she is taking the medication and provided education on how to record appropriately. 2.All residents requesting to self administer medications will have a current assessment completed and care planned accordingly. 3. Nursing staff education will be completed by February 18, 2013, trained on policy and procedure of self administration of medications. 4.The DNS and/or her designee will conduct one audit weekly on any residents requesting to self administer medications, and current residents doing Self Administration for proper med storage and documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2 have inhaler at bedside. The facility failed to assess R16 to determine if she was safe to self administer this medication, and failed to have a system in place to determine how often R16 was utilizing this medication. Review of the facility's policy, Self-Administration of Medications with a revision date of 10/21/10 indicated an assessment for self-administration of medications must be completed by an RN prior to actual self-administration, residents must be reassessed quarterly and the resident is to be given a copy of their monthly MAR to record their administration daily.	F 176	5. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident #63 has had his pressure ulcer comprehensive assessment, Braden scale and care plan updated, and reviewed with the IDT team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 residents with a pressure ulcer (R63) had a plan of care which addressed wound care; the facility failed to include the interventions for using tab alarms for 1 of 4 residents (R9) with accidents. Furthermore, the facility failed to develop a comprehensive plan of care for 2 of 2 residents (R75 and R45) who received hemodiaylsis. R63's care plan did not address pressure ulcer wound care. R63's diagnosis included pressure ulcer of the right heel. The quarterly minimum data set (MDS) dated 11/6/12, indicated R63 received total assistance with bed mobility and had an unstageable pressure ulcer which measured 10.8 by 9.0 by 0.1 centimeters (cm). The care area assessment (CAA) dated 8/3/12, indicated R63 had pressure ulcers and care planning would be completed. R63's hospital discharge orders dated 11/16/12, included "avoid pressure on heel area and off loading it will be important. continue with wound care and boot as started this hospital stay." R63's care plan dated 11/16/12, indicated R63 "has potential for pressure ulcer development..." and goal indicated he "will have intact skin, free of redness, blisters, or discoloration..." Staff instructions included to moisturize skin daily, use lift sheet for repositioning, use redistribution mattress, monitor nutritional status. The care plan	F 279	2. All residents with current pressure ulcers assessments and care plans were updated accordingly. Facility will continue to update care plans as per facility policy and procedure. 3. All residents are assessed for pressure ulcers upon admission, quarterly, and with significant change in condition. 4. Nursing staff education will be completed by February 18, 2013,, to include proper assessment of risk factors and care plan expectations. 5. The DNS and/or her designee will conduct two audits weekly for one month and then once weekly for two months for completion of proper assessment and appropriate care plan. 6. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 did not identify that R63 had a current pressure ulcer, nor was the hospital discharge orders of avoiding pressure identified in the care plan along with other interventions or treatments to assist in healing R63's pressure ulcer. A review of the facility's Pressure Ulcer Guidelines, dated 10/21/10, included under Policy, "The individualized care plan addresses prevention strategies, reassessments of the effectiveness of interventions and revisions/modifications based on new information, a change in the resident's condition or a new intervention." On 1/9/13 at 2:21 p.m., registered nurse (RN)-C verified R63's care plan had not been updated to include an actual pressure ulcer. Even though R63 had pressure ulcers identified on the CAA dated 8/3/12, and the CAA indicated care planning would be completed, the facility failed to review and revise R63's comprehensive plan of care. R9 was admitted to the facility on 10/2012 and had 11 documented falls since admission. The care plan was not updated to include interventions to help reduce the risk of falls. R9 has diagnoses that include: urinary incontinence, depression and anxiety. R9's admission Minimum Data Set (MDS) dated 10/27/2012 included she had moderate cognitive impairment and required extensive assistance of staff for activities of daily living (ADL's).	F 279	F 279 continued The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident # 9 a new fall risk analysis was completed on 1/25/2013. A new bowel and bladder assessment was also completed on 1/24/2013. Care plan updated accordingly with findings of new assessments and current fall interventions. Reviewed with IDT	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 279

Continued From page 5

Review of "undated nursing assistant care sheet", instructed staff to toilet resident every 1.5 hours and pressure sensor in bed. There was no mention of the TABS alarm.

Review of "untitled document" for January 2013, indicated "Pressure pad sensor when in bed. No need to ckip [sic] tabs to resident Start Date: 11/16/2012 D/E/N (day/evening/night) Everyday."

During interview on 1/9/2013 at 12:55 p.m., nursing assistant (NA)-D stated the TAB alarm should be attached to R9 at all times, and they attached the alarm to the back of R9's sweater.

Review of R9's care plan, last updated 11/26/12, indicated R9 should be toilet resident every 1.5 hours to prevent falls, pressure pad sensor while in bed, and ambulate resident to lunch and supper and to toilet to prevent falls. There was no indication that R9 had a personal protective alarm (TABS) to alert staff when she moved.

During interview on 1/10/13 at 3:15 p.m. the director of nursing stated R9's TABS alarm may not be appropriate for her at this time and verified this was not identified on the care plan.

The facility failed to complete a comprehensive care plan to include access site, special care, and emergency procedures for R45 and R75 who received hemo-dialysis.

R45 was diagnosed with end stage renal disease. The annual Minimum Data Set (MDS) dated 11/02/12 identified R45 as cognitively intact, independent with all activities of daily living (ADLs), and received hemo-dialysis.

F 279

2. Staff care sheets have been updated to reflect current fall interventions and toileting schedule.
3. Education regarding care sheet updating and proper alarm placement will be provide by February 18, 2013.
4. The DNS and/or her designee will complete two audits per week for one month then weekly for two months.
5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies.

Completion date: February 19, 2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 During review of R45's care plan, last revised on 11/01/12, indicated resident receives "hemo-dialysis three times a week related to stage four chronic kidney disease, scheduled dialysis days are Mondays, Wednesdays and Fridays with transport by Care Cab and staff to observe/ document to medical practitioner/ nurse PRN [as needed] for s/sx [signs and symptoms] of the following, bleeding, hemorrhage and septic shock. There was no information regarding; the access site location, checking bruit and thrill daily or whom the facility should contact, if R45 was unable to get to dialysis due to weather related concerns. When interviewed on 01/11/13, at 9:50 a.m. the director of nursing verified there was no dialysis information on R45's and R75's care plan regarding emergency procedures, where the access site was located and any special cares needed. R75 was diagnosed with end stage renal disease. The admission MDS dated 12/27/12 identified R75 as cognitively intact, extensive assist with ADLs, and received hemo-dialysis. During review of R75's care plan, last revised on 01/02/13, indicated resident "needs hemo-dialysis related to end stage renal disease, check and change dressing at access site. Document. Receives dialysis Monday, Wednesday and Friday- p/u [pick up] at 0530, and staff to observe/ document to medical practitioner / nurse PRN [as needed] for s/sx [signs and symptoms] of the following, bleeding, hemorrhage and septic	F 279	F 279 continued The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident # 45 care plan was updated on 2/4/2013, to include access site, special care and procedures. 2. Resident # 75 care plan was updated on 2/6/2013, to include access site, special care and procedures. 3. Education regarding emergency dialysis procedures will be provided by February 18, 2013, 4. The DNS and/or her designee will complete two audits per week for one month then weekly for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 shock." There was no information regarding; access site location, checking bruit and thrill daily and whom the facility should contact, if R75 was unable to get to dialysis due to weather related concerns. When interviewed on 01/11/13, at 9:50 a.m. the director of nursing verified there was no dialysis information on R45's and R75's care plan regarding emergency procedures, where the access site was located and any special cares needed. No further information was provided.	F 279	5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate care with dialysis, and failed to ensure staff were aware of the necessary care and services for 1 of 2 residents (R75) who received hemodialysis. Findings include: R75 had diagnosis of end stage renal disease and received hemo-dialysis. The admission	F 309	F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Education provided to RN-E on January 11, 2013, regarding how to check bruit and thrill, and procedures to follow if not present.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 minimum data set (MDS) dated 12/27/12, identified R75 was cognitively intact, and required extensive assist with activities of daily living (ADLs). During review of Centra Care Kidney Program Plan of Care, last updated on 01/07/13, indicated R75 access site was "AVF [arterial/ venous fistula]." R75's Dialysis Communication Record, dated 01/02/13, 01/07/13 and 01/09/13, indicated R75's access site was checked for bruit and thrill (pulse) present by registered nurse (RN)-E, which was indicated as "no". On 12/23/12, 12/28/12, the question on the forms were not completed if the bruit and thrill were present prior to transport to an off-site dialysis unit. All five of the forms had been completed by RN-E. R75's care plan dated 01/02/13, failed to include information regarding dialysis access site location, checking bruit and thrill daily, or whom the facility should contact, if R75 was unable to get to dialysis due to weather related concerns. When interviewed on 01/11/13, at 6:32 a.m. RN-E stated, she listens for the bruit and thrill on R75 since she leaves for dialysis on the night shift and RN-E documents on the Dialysis Communication Record which goes between the dialysis unit and nursing home. RN-E was asked about 01/02/13, 01/07/13 and 01/09/13 Dialysis Communication Record and the forms indicating the bruit and thrill were not present. RN-E stated the bruit and thrill is, "the pulse and you don't want to hear the pulse by the access site." RN-E verified staff did not check for the bruit and thrill	F 309	2. Education to be provided to all nursing staff by February 18, 2013, regarding dialysis procedures, and daily tracking of bruit and thrill. 3. Procedure put in place to track bruit and thrill daily on all residents receiving dialysis. 4. The DNS and/or her designee will complete two audits weekly for one month and then one audit weekly for two months. 5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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. No further information provided.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor on a weekly basis pressure ulcer status for 1 of 1 residents (R63) in the facility currently with a pressure ulcer. Findings include: R63's diagnosis included pressure ulcer of the right heel. The quarterly minimum data set (MDS) dated 11/6/12, indicated R63 received total assistance with bed mobility and had an unstageable pressure ulcer which measured 10.8 by 9.0 by 0.1 centimeters (cm). The pressure ulcer care area assessment (CAA) dated 8/3/12, indicated R63 had pressure ulcers and care planning would be completed. R63's wound care was observed on 1/10/13 at 2:03 p.m., with RN-C. RN-C described the wound bed as slough, surrounding area as pink, and measured 5.5 cm x 2.25 cm with no depth, only slough, and a Stage 3 pressure ulcer. Review of progress notes identified on 10/7/12, "Resident noted to have an intact blister on his	F 314	F 314 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Residents # 63 has had reevaluation of his wounds, facility has consulted with the wound clinic. Review and completion of comprehensive assessment, Braden scale and care plan updated. Dietary has reviewed diet. 2. Reviewed all residents with alterations in skin. Care plans have been reviewed, Weekly wound rounds have been reviewed. 3. Nursing staff education will be completed regarding wound protocols by February 18, 2013, 4. The DNS and/or her designee will conduct two audits weekly for one month and then once weekly for two months for completion of proper assessment and appropriate care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 right medial heel measuring 4 cm x [times] 4 cm. Dr. Hemming updated per fax. Applied an aleven [name brand dressing] to the area and put in tx [treatment] book to monitor." The progress notes indicated that R63 was hospitalized on 11/7/12 and remained in the hospital until 11/16/12. The 11/16/12 hospital discharge summary, indicated the pressure ulcer to his right heel was infected, required surgical debridement, and required antibiotics upon admission to the hospital. The discharge orders identified R63 was to "avoid pressure on heel area and off loading it will be important. Continue with wound care and boot as started this hospital stay." The treatment to right heel pressure ulcer included to: "Cleanse area with wound cleaner, apply Santyl (a debriding ointment) applied to wound bed only, calmoseptine (a protectant) applied around wound bed on intact skin. Vaseline gauze, cover with gauze, wrap with kerlex. Apply Royal (name brand) contracture boot. Off-load area every 2 hours." A review of R63's progress notes, daily and weekly wound documentation following hospital discharge on 11/16/12 included a weekly "body audit," each body audit noted a right heel pressure ulcer, but did not identify any wound characteristics. The "Daily Wound Monitoring" sheets identified drainage type, amount, surrounding skin color, and pain. "Skin/wound notes" identified the following: 11/21/12 "Heel has moderate amount of yellow-greenish slough present. Area around pressure area is light pink-no s/sx	F 314	5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ________ B. WING ________	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 (signs/symptoms) of infection noted. Area is approx (approximately) 7 inches in diameter with edges jagged. Moderate amount of drainage present on old dressings when removed." 11/23/12 "Heel is a stage 3... Has yellow/white slough present. No necrotic tissue noted. Area has granulation present in bed of the wound. Copious amount of sanguineous drainage present. Slight odor noted when dressing was removed. " 11/28/12 "Large amount of yellow, green drainage noted on old dressing when removed. Had foul odor present upon removal of dressing, however, after cleansing site odor was resolved. Area has large amount of slough present thereabout wound bed. Tissue surrounding wound bed is pink and skin is flaky...Measurement of wound site is 8 cm in diameter. No tunneling noted." 11/29/12 "Moderate amounts of serous drainage noted on old dressing." 12/4/12 "Right heel dressing was changed this shift and there was a small amount of serosanguineous drainage on old dressing...Area on heel appears to be healing nicely and site appears smaller than it has previously." 12/24/12 "No tunneling/odor noted. Wound bed has granulation and slough present. Moderate amount of yellow/green drainage on removed dressing. No s/sx of infection. Measurements: 4 cm diameter, 2.25 cm length, 3.75 cm width. Ulcer is healing without complications." There were no additional notes regarding monitoring of	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 the pressure ulcer in December, which was only completed twice. 1/3/12 "Wound bed presents with granulation. Small area on lower edge of wound has slough present. Surrounding tissue is pink and intact. No signs of infection noted. Measurements: 1.75 in width, 2.25 in length, 3 cm in diameter. Wound is resolving without complication at this time." The facility did not consistently monitor the pressure ulcer size, which included length, width, depth and stage of the pressure ulcer on a weekly basis. R63's care plan dated 11/16/12 identified R63 was at risk for the development of pressure ulcers, but did not identify R63 had a current pressure ulcer or what treatment should be completed for the current pressure ulcer. During interview on 1/9/13 at 2:21 p.m., registered nurse (RN)-C stated R63's pressure ulcer was 8 inches in diameter and had a foul odor on 11/7/12. R63 went to the hospital and came back with an order for weekly visits to the wound clinic. RN-C verified weekly documentation of wound size had not been consistently monitored on a weekly basis and noted some nurses document the wound in diameter, others document in length by width by depth. She herself only measures in diameter. She verified R63's care plan had not been updated to include R63's current pressure ulcer. A review of the facility's Pressure Ulcer Guidelines, dated 10/21/10, included under	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 Policy, "The individualized care plan addresses prevention strategies..." Also included in the guidelines, under Identification and Treatment of Pressure Ulcers, "Describe the pressure ulcers stage (Stage I, II, III, or IV)...Describe and monitor ulcer characteristics weekly and as necessary documenting the following: location and staging, size...exudates...pain...wound bed...description of wound edges and surrounding tissue..." Also included, were guidelines was a description of how to stage a pressure ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and consistently implement fall interventions for 1 of 1 residents, (R9) reviewed with falls. Findings include: R9 was admitted to the facility on 10/2012 with diagnoses that include: urinary incontinence, depression and anxiety. R9's admission Minimum Data Set (MDS) dated 10/27/2012 included moderate cognitive impairment and required	F 323	F 323 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident # 9 a new fall risk analysis was completed on 1/25/2013, and care plan updated accordingly with current fall interventions. A new bowel and bladder assessment was also completed on 1/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 extensive assistance of staff for activities of daily living (ADL's). During observation on 1/9/2013 at 12:51 p.m., R9 was observed leaving the dining room, her TABS alarm was not attached to the resident shirt and the alarm was hanging off her wheelchair. At 12:55 p.m., nursing assistant (NA)-D stated the alarm should be attached to R9 at all times and reattached TABS alarm to the back of R9's sweater. During continuous observation on 1/10/13, from 8:15 a.m. to 10:12 a.m. R9 was in the dining room in her wheelchair eating breakfast. The tab alarm was clipped to the back of her shirt within reach of the resident. At 8:35 a.m., R9 wheeled to the day room and at 8:38 a.m., R9 was brought to bedroom by licensed practical nurse (LPN)-A for an insulin injection. At 8:40 a.m., R9 was brought back to the dayroom to watch TV. At 8:41 a.m. LPN-A and surveyor observed R9's bed, a pressure sensor was between the sheets, but the sensor was not plugged into the wall, making it inoperable. At 9:40 a.m. R9 continued to participate in activities and watched television in the dayroom until 10:10 a.m. At that time R9 started to stand up and the activities director brought her to her room and turned the call light on for help. At 10:12 a.m. nursing assistant (NA) -A went into R9's room and assisted her to the bathroom. During interview on 1/10/13 at 10:16 a.m. NA-A, stated R9 went to the bathroom and voided. She stated R9 was to be toileted every 2 hours which is kept track on the computer. She was unsure of when R9 was last toileted and checked the	F 323	2. Staff care sheets have been updated to reflect current fall interventions and toileting schedule. Each facility fall will be evaluated for correlation to toileting schedule and reviewed by the IDT 3. Education regarding care sheet updating and proper alarm placement will be provided by February 18, 2013 4. The DNS and/or her designee will complete two audits per week for one month then weekly for two months. 5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 computer. NA-A stated R9 was last toileted at 9:52 a.m., 20 minutes before R9 was toileted at 10:12 a.m. NA-A was informed that R9 was continuously observed and had not been taken to the bathroom during that time. NA-A stated she did not take R9 to the bathroom at that time, but had been charting in R9 electronic record. She was unsure the last time R9 had been taken to the bathroom. During interview on 1/10/13 at 2:26 p.m. NA-B, stated she toilets R9 every 2-3 hours, before and after meals, when we get her up and lay her down and when she puts her call light on. During interview on 1/11/13 at 7:03 a.m. NA-C, stated he works nights and gets R9 up about 3-4 times a night and we check her at rounds, which is 12:00 a.m., 2:00 a.m. and 4:00 a.m..NA-C also stated, sometimes she tries to get up herself, and the alarm sounds so we toilet her at that time also. Review of the progress notes indicated R9 had 11 falls since admission to the facility from 10/26/12 through 12/25/12. The progress notes identified the following: On 10/26/12, R9 was found on the floor by staff next to her bed at 1:55 a.m., R9 stated she was trying to get to the toilet. The facility implemented the interventions of frequent toileting, call light within reach and education to use the call light. On 10/31/12, R9 was found by staff on her floor mat next to bed at 8:50 p.m. The interventions implemented were to remind resident to use call light and staff to toilet her every 1.5 hours. On 11/4/12, R9 was found on floor by staff in her	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 bathroom at 7:15 p.m. The interventions implemented included a pad sensor in R9's bed. On 11/15/12, R9 was found on by staff on her floor mat next to her bed at 5:00 a.m. The alarm was sounding, but R9 had removed her personal safety alarm (TABS) alarm and was placed back on R9. The interventions implemented were bed in lowest position, call light in reach of resident, and TABS alarm on while R9 was in bed. On 11/16/12, R9 was found on her floor by staff at 5:15 a.m.. She told staff she was trying to use the commode and had removed the tabs alarm. The interventions implemented were to move R9 closer to the nursing station, re-educate staff regarding frequency of toileting at night and pharmacy reviewed medications which were unlikely to be a contributing factor to the falls. On 11/26/12, R9 was found by staff on her floor mat next to her bed at 1:15 a.m.. The resident was trying to get to bathroom, TABS alarm was not connected and the sensor pad was not plugged into the wall, making it inoperable. The interventions implemented were to re-educate staff on the placement of the TABS alarm. On 12/17/12, R9 was found by staff on her floor mat next to her bed at 4:40 p.m.. The resident stated she needed to use the bathroom and the staff verified they had not toileted R9 yet that shift. The interventions implemented were to re-educate the staff on the use of TABS alarm and toileting schedule. On 12/19/12, R9 was found on floor by staff next to her bed at 9:55 a.m. and the TABS alarm was	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 not attached to resident. The interventions included to re-educate the resident on the use of the call light and remind not to remove the TABS alarm. On 12/24/12, R9 was found by staff on the floor by her bed at 4:40 p.m. The interventions implemented were to remind the resident to use her call light. On 12/25/12, R9 was found by staff on her bathroom floor at 8:15 a.m. with her TABS alarm sounding. The interventions implemented was to re-apply the TABS alarm to R9's shirt. On 12/25/12, R9 was found by staff on the floor in dining room at 2:30 p.m.. She had slipped out of her wheelchair and the TABS alarm was attached to her sweater but R9 had removed her sweater. The interventions implemented were to make sure the TABS alarm was on R9 and working. Review of the falls identified R9 had a pattern of falls. Four of the 11 falls were during the night shift between 1:15 am and 5:15 a.m.; 4 of 11 falls were in the evening between 4:40 p.m. and 8:50 p.m. All of these 8 falls, identified R9 was either in her room next to her bed or in the bathroom. There was only 3 of the 11 falls during the day shift, and 2 of these 3 falls were in the residents room or bathroom. There was only one fall, in which R9 had slipped out of her wheelchair. Review of facility Fall Risk Analysis dated 10/20/12, indicated resident had vision, impairment, hearing loss and sensory loss, balance problems with standing and walking, lower extremity weakness and needs toilet	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 assistance. The assessment indicated R9 had recent falls in past month and previous falls related to health condition with dizziness, loss of balance and weakness. Although R9 had multiple falls since the 10/20/12 analysis, there was no comprehensive fall assessment to identify if there was a pattern of falls to determine which interventions could be effective to help decrease R9 risk of falling. Review of R9's care plan, last updated 11/26/12, identified the problem of falls and directed staff to toilet the resident every 1.5 hours, use pressure pad sensor while in bed, ambulate the resident to lunch and supper and toilet to prevent falls. The resident uses her call light minimally, and does not always know what the call light is. The care plan did not address the use of a TABS alarm. During interview on 1/10/13 at 3:15 p.m. the director of nursing reviewed R9 falls and stated they placed a variety of interventions which included toileting, sensor pads, tabs alarm, using dycemen in her wheelchair so it wasn't as slippery, moving her closer to the nursing station and having the pharmacist review her medications to determine if medication could be related to her falls. The DON was unsure if the tabs alarms were appropriate for R9 since she continues to remove the device. She went on to say since moving R9 closer to the nursing station and using the dycemen, R9's falls have decreased and acknowledged the interventions of reminding R9 to use her call light was not appropriate. Even though R9 had a pattern of falls in her room and bathroom during the evening and night shift.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 The facility did not identify this pattern to determine an appropriate toileting schedule for R9 during these times. R9's toileting schedule varied from every 1.5 hours, to every 2-3 hours, to before and after meals or when she attempts to get up from her chair. R9 was observed not to be toileted timely and attempted to stand when she needed to use the bathroom. Also R9's alarm and sensor pads were not consistently applied to reduce R9 risk of falls even though this was identified as an intervention by the facility. R9's falls were not comprehensively assessed to determine appropriate interventions to help reduce the risk of falling nor was the facilities fall interventions consistently implemented. No further information was provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F 329 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident #24, non-pharmacological interventions added to care sheet. Medication regimen was reviewed by Consultant Pharmacists	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor efficacy of medications prescribed for 2 of 10 residents (R24 and R43)who were reviewed for unnecessary medications. Furthermore, the facility failed to ensure ongoing justification of medication use for 1 of 10 residents (R57) who were reviewed for unnecessary medications. R24 received as seroquel and the efficacy of this medication was not consistently monitored. R24 diagnoses included stage Alzheimer's disease (currently receiving Hospice benefit), dementia with behavioral disturbances, anxiety and depression. The significant change minimum data set (MDS), dated 10/16/12, indicated R24's cognition was not able to be screened, and had inattention and disorganized thinking. The Psychotropic Drug Use Care Area Assessment (CAA), not dated, indicated R24 was receiving Remeron (anti-depressant) for depression and Seroquel (anti-psychotic) for dementia with behavioral disturbance. The CAA indicated dose reductions had been made in the past, the seroquel had recently been increased while at a in house Geriatric psychiatric unit, and R24 was currently receiving hospice cares.	F 329	2. Resident #57 will have medication regimen reviewed by Consultant Pharmacist on February 7, 2013. 3. Staff will be educated on procedure for PRN usage and documentation, in addition to using non pharmacological interventions prior to administering the PRN, by February 18, 2013. 4. The DNS or designee will complete two audits per week for one month and then one audit per week for two months on PRN usage 5. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: February 19, 2013	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22 R24's physician orders dated 12/21/12 included the following: Remeron 22.5 milligrams (mg) at bedtime for depression, Seroquel 75 mg twice a day for aggressive physical/verbal behaviors and misperceptions, and Seroquel 25 mg twice a day as needed for aggressive physical/verbal behaviors, or misperceptions. R24's medication administration records (MARs), R24 received the "as needed" Seroquel on 8 occasions between 10/18/12 and 11/14/12. In review of the "as needed follow up charting", 7 of the 8 dosing's were given for some form of physical and/or verbal aggression. The 8th dose was documented at "states she feels anxious". In the "Result" section, staff had only documented on 2 dosing: 10/24/12 "not effective" and 11/12/12 "resting". The other doses had not been followed up on. R24's nursing progress notes associated with the 8 dosing's were review and the following was noted: 10/18/12 at 5:00 p.m. "Resident proceeded to grab nursing assistant by the hair and scratch nursing assistant. Resident was given "as needed" Seroquel per doctors orders for behavior." However, there was no documentation of non-pharmological interventions. 10/24/12 at 7:20 p.m. "Resident continued to yell out for an hour after she was laid in bed this evening. When staff asked her what she needed, resident was unable to answer. Nursing will continue to monitor resident and her behavior." However, there was no documentation of	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 Seroquel being given or other non-pharmological interventions. 10/26/12 given twice at 1:35 p.m. and 4:00 p.m. "Resident did scratch daughter, when daughter tried to stop resident from hitting another resident." The staff documented twice more that day, while they had placed resident on 15 minute checks, there was no documentation that the "as needed" Seroquel was given until the last entry at 9:11 p.m.. Furthermore, there was no documentation of non-pharmological interventions being tried prior to given Seroquel. 11/27/12 at 6:00 p.m. "As needed Seroquel was given after redirection and multiple attempts at altering resident's behavior did not work. Resident is resting quietly in bed at this time." 10/29/12 at 9:29 p.m. "Resident slapped nurse on the butt and was wandering throughout the halls most of shift. As needed Seroquel was given per parameters but was not effective for behaviors. Resident also was yelling at nurse and other residents., but when asked what she needed or if there was a problem she would say no and swat out at the nurse/staff. Nursing will continue to monitor." Furthermore, there was no documentation of non-pharmological interventions being tried prior to given Seroquel. 11/12/12 at 1:05 p.m. The "as needed follow up charting" documented the reason for giving Seroquel was "slapped other resident shoulder." However, the electronic progress notes indicated only, "resident has been wandering around the halls this shift. Resident was making faces and noises at other residents this evening, but staff	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 separated the residents." 11/14/12 at 1:35 p.m. "Resident has not had any behaviors noted this shift. She did state that she felt anxious and did receive a "as needed" seroquel. She is resting at this time." R24's care plan dated 1/26/11 included a problem for Behaviors indicated "resident has potential to demonstrate physical behaviors (hitting, pushing, grabbing) towards staff and other residents." Staff were directed to redirect resident to a safe place, provide appropriate activities as she allows, intervene before agitation escalates, engage calmly in conversation, and if resident is aggressive, staff walk calmly away and re-approach at a later time. On 01/11/13 at 8:30 a.m., registered nurse (RN) -B stated the facility's documentation lacked indications of non-pharmological interventions, or the appropriate use of the "as needed" seroquel. No further information was provided. R43's received Vicodin (a narcotic pain reliever) as needed for pain. The medication was not adequately monitored to determine if the medication was effective. R43's diagnoses included spondylosis, osteoarthritis and osteoporosis. The quarterly minimum data set (MDS) dated 12/20/2012 indicated moderate cognitive impairment and required extensive assistance from staff for activities of daily living (ADL's). R43's physician's orders dated 11/26/2012	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 included: Hydrocodone APAP (Vicodin) 5/325 mg, 1 tab every 4 hours as needed for musculoskeletal pain. R43's Medication Administration Record dated 11/26/2012 through 1/8/2013, indicated R43 received 33 doses of prn (as needed) Vicodin. The PRN Follow Up Charting, dated 11/26/2012 through 1/6/2013 indicated Vicodin was identified 4 out of 33 times being effective. The rest were blank. The progress notes dated 10/23/12 through 1/8/13, only identified on 12/16/12, the PRN Vicodin was effective, there were no other entries that identified R43 pain and if the medication was effective. During interview on 1/10/13 at 2:46 p.m. with licensed practical nurse (LPN)-D, stated she charts the effectiveness of pain in the prn follow up sheet under results after an hour and or two. She was unsure why this was not being consistently implemented to determine if the medication was effective. During interview on 1/11/13 at 8:40 a.m. with registered nurse (RN)-E, stated staff should be documenting on the prn follow up charting form if the pain medication is effective. At 9:01 a.m. with RN-B, stated it was standard to follow up on prn pain medications but this was not consistently"being done." During Interview on 1/11/13 at 9:40 a.m. with the consultant pharmacist (Pharm-D), stated that staff need to be following up on the results of effectiveness when administering prn Vicodin A facility policy entitled PRN Medications dated	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26	F 329		

10/21/10, included, "If prn meds are needed, assessment of the resident's condition must be completed prior to administration." The policy also indicated, "PRN meds are to be documented on the "PRN medication follow-up sheet" which is located in the MAR. The follow-up sheet is to be used for all prn meds so appropriate follow-up on effectiveness of the medication is completed."

No further information was provided.

R57 received antidepressant and anti-anxiety medications without justification for the use of these medications at the current dose.

R57 diagnoses included depression, anxiety and panic attacks. The annual minimum data set (MDS), dated 11/27/12, indicated R75 was receiving both antidepressant and anti-anxiety medications, was cognitively intact. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/27/12, indicated only the following: "Resident has a history of and diagnoses of depression, he is not displaying signs of depression at this time. He states that his depression is well managed and that he feels good. No concerns noted at this time."

R57's physician orders dated 12/21/12 included Buspar (anti-anxiety medication) 5 milligrams (mg) twice a day for anxiety, Remeron (antidepressant) 22.5 mg every bedtime for depression, Zoloft 50 mg (antidepressant / anti-anxiety) every bedtime for panic attacks and clonazepam (anti-seizure medication sometimes used for panic) 0.5 mg twice a day as needed for anxiety.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 R57's care plan dated 12/13/12 included use of antidepressant and antianxiety medications. R57's psychiatrist progress notes dated 11/1/12, the notes indicated R57's anxiety was stable, to continue the current medications and would be seen in 3 months. However, in review of the licensed psychologist progress notes, dated 11/28/12, the notes indicated R57 continued to have trust issues which caused anxiety and the treatment plan was to continue to explore ways R57 could have more realistic expectations of himself and others. The notes failed to address ongoing need for antianxiety, or antidepressant medications at their current doses. During interview on 01/11/13 at 8:30 a.m., a registered nurse-X verified that ongoing justification was lacking for R57's psychotropic medications at their current doses.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356	F356 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Medical Records or designee will create posting, night RN will post daily 2. Audits will be done daily for 2 weeks, than weekly for two months	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 28 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post the required nurse staffing information on a daily basis. This had the potential to affect the 44 residents currently residing in the facility, and any visitors. Findings include: During the initial tour observation on 1/8/13 at 11:55 a.m., the daily staff posting was hanging on a bulletin board outside the nurse's station. The date on the staff posting was 12/14/12, 25 days ago. During interview on 1/8/13 at 11:55 a.m., director of nursing (DON) verified the current staff posting was 25 days old, dated 12/14/12. The DON stated the medical records person was responsible for updating the staff posting daily, however, the medical records person resigned at	F 356	3. The data collected will be presented to the QA Committee by the Dietary Manager. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 29 the beginning of December. DON stated no one had been assigned to ensure the staff posting of hours was updated daily. The facility was unable to provide any daily staff postings since 12/14/12. No further information was provided.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food service was done in a sanitary manner to prevent the spread of food borne illness. This had the potential to affect all 44 residents currently residing in the facility. Findings include: During food service observation, Cook-A was observed touching multiple surfaces with dirty gloved hands and then picking up plates and bread without changing her soiled gloves.	F 371	F 371 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Dietary staff were educated on proper glove use on January 17, 2013 2. The DOD and/or her designee will complete 5 audits per week for one month than 2 audits a week for two months on random staff.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 30 During observation on 1/8/13 at 12:05 p.m., Cook-A was observed picking up and touching surface of plates, touching handles to serve food, then picking up bread with her soiled gloved right hand and placing bread on plate. At 12:06 p.m., Cook-A brought a tray to the refrigerator, opened the refrigerator with gloved hand and placed tray in refrigerator. Cook-A did not change gloves after touching the tray and the refrigerator handle. At 12:07 p.m., Cook-A was observed multiple times to pick up a slice of bread with soiled gloves and place the bread on the plates. At 12:11 p.m., Cook-A opened the refrigerator door with gloved hands and removed the butter. At 12:15 p.m., Cook-A picked up plates where food is placed and touched bread with her soiled gloves. Cook-A continued this same process without first changing her soiled gloves. During interview on 1/8/13 at 12:20 p.m. Cook-A, stated she put gloves on right before she started serving and does not change her gloves during serving. During interview on 1/11/13 at 7:55 a.m. with the director of dietary (DOD)-D, stated that it was inappropriate for Cook-A to touch multiple surfaces while wearing gloves and then pick up pieces of bread with the same soiled gloves. DOD-D stated that was not acceptable practice and that is cross-contamination. I have a meeting scheduled next Thursday on glove usage and sanitation; I have had to talk to some people about proper glove use. During review of Dietary Department Responsibilities dated 1/10, indicated employees will wear vinyl or plastic gloves when handling	F 371	3. The data collected will be presented to the QA Committee by the DOD. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 31 ready-to-eat foods and all employees will be required to wash hands as frequently as needed between tasks. No Further information was provided.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure that narcotic medication patches were destroyed according to manufacturer's instructions and facility policy for 1 of 1 residents (R 34) in the sample who utilized Fentanyl patches.	F 425	F 425 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. All nursing staff were immediately educated on facility policy and procedure. We will review this education with all nursing staff by February 18, 2013. 2. The DNS or designee will do 2 audits per week for 1 month, and then 1 audit weekly for 2 months to assure compliance.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 32 Findings include: During medication observation on 01/08/13 at 7:40 p.m., registered nurse (RN-A) began setting up the evening medication for R34, one of which was a Fentanyl patch 12 microgram (mcg) (a transdermal narcotic dispensing system). After entering the R34's room, and oral medications were given, RN-A removed the prior Fentanyl patch from the right side of this resident's back and placed the new patch on her left side. Then RN-A, went to the nurses station, stated that she needed to find another nurse to witness destruction of the old patch. Once at the station, she requested the assistant director of nursing (ADON) to witness the destruction, and proceeded to cut up the patch with a pair of scissors in her gloved hand. Once the patch had been cut up several times, RN-A pulled the glove off her hand (inside out) and threw the patch and glove in the wastebasket. During interview back to the medication cart on 01/08/13 at 8:05 p.m., RN-A stated that the manner in which she destroyed that patch was how she was instructed by the facility. In review of the facility's policy, entitled: Transdermal Patches (Administration), last revised 11/19/12, procedure nine directed the facility staff to do the following: "When removing any patches, they are to be disposed of by folding and placing sticky surfaces together. If patch is of a controlled substance, it is to be disposed of by flushing down the toilet. The destruction does need to be witnessed by another licensed staff and documented in the MAR(medication	F 425	3. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: February 19, 2013	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 33 administration record)." In review of the manufacture's instructions, page 27 instructed users of Fentanyl patches to destroy in the following manner: "Used patches should be flushed down the toilet immediately upon removal." During interview on 01/08/13 at 8:14 p.m., the director of nursing (DON) and the facility administrator (ADM) both verified and stated that the patch was not destroyed according to manufacture's instruction nor facility policy. No further information was provided.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the pharmacist identified inadequate monitoring of pain medications for 1 of 10 residents (R43) reviewed for unnecessary medications. Furthermore, the facility failed to ensure that pharmacy recommendations were	F 428	F428 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Staff will be educated on procedure for PRN usage and documentation of effectiveness, by February 18, 2013. 2. Review Pharmacists recommendations and facility follow up after each monthly visit	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 34 acted upon by the physician for 1 of 10 residents (R57) reviewed for unnecessary medications. Findings include: R43's received Vicodin (a narcotic pain reliever) as needed for pain. The pharmacist did not identify the facility was not adequately monitoring the medication to determine if it was effective. R43's diagnoses included spondylosis, osteoarthritis and osteoporosis. The quarterly minimum data set (MDS) dated 12/20/2012 indicated moderate cognitive impairment and required extensive assistance from staff for activities of daily living (ADL's). R43's physician's orders dated 11/26/2012 included: Hydrocodone APAP (Vicodin) 5/325 mg, 1 tab every 4 hours as needed for musculoskeletal pain. R43's Medication Administration Record dated 11/26/2012 through 1/8/2013, indicated R43 received 33 doses of PRN (as needed) Vicodin. The PRN Follow Up Charting, dated 11/26/2012 through 1/6/2013 indicated Vicodin was identified 4 out of 33 times being effective. The rest were blank. The progress notes dated 10/23/12 through 1/8/13, only identified on 12/16/12, the PRN Vicodin was effective, there were no other entries that identified R43 pain and if the medication was effective. Review of "Consultant Pharmacist Drug Regimen Reviews" dated 6/22/12 through 12/14/12	F 428	3. The DNS or designee will complete two audits per week for one month and then one audit per week for two months on PRN usage. 4. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 35 indicated the consulting pharmacist did not acknowledge that staff were not documenting the effectiveness of as needed Vicodin. During Interview on 1/11/13 at 9:40 a.m. with the consultant pharmacist (Pharm-D), stated that staff need to be following up on the results of effectiveness when administering PRN Vicodin. No further information was provided. R57 received various antidepressants, and antianxiety medications. The pharmacist identified there was no clinical indications by the physician of why a dose reduction attempt is clinically contraindicated for these medications. The physician did not act on these concerns. R57 had the diagnoses of depression, anxiety and panic attacks. The Annual minimum data set (MDS), dated 11/27/12, indicated that R75 had the active diagnoses of depression and anxiety, was receiving both antidepressant and anti-anxiety medications, and was alert and orientated. The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/27/12, indicated, "Resident has a history of and diagnoses of depression, he is not displaying signs of depression at this time. He states that his depression is well managed and that he feels good. No concerns noted at this time." R57's current physicians' orders identified Buspar (anti-anxiety medication) 5 milligrams (mg) twice a day for anxiety, Remeron (antidepressant) 22.5 mg every bedtime for depression, Zoloft 50 mg	F 428		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 36 (antidepressant / anti-anxiety) every bedtime for panic attacks and clonazepam (anti-seizure medication sometimes used for panic) 0.5 mg twice a day as needed for anxiety. The consulting pharmacist reviews identified the following: 10/16/12: "when resident goes to psychiatry, facility will need documentation why dose reduction attempt is clinically contraindicated for each psych med or decrease, if possible." 11/16/12: "I believe psychiatry review is pending." 12/14/12: "Could we request a copy of psychiatry's most recent dictation? Facility needs documentation as to why any decrease is contraindicated for psychotropic medications. (if this documentation is not in the dictation, then they would need to be faxed to request gradual dose reduction documentation.)" In review of the psychiatrist progress notes, dated 11/1/12, the notes indicated only that R57's anxiety was stable, to continue the current medications and would be seen in three months. However, in review of the licensed psychologist progress notes, dated 11/28/12, the notes indicated R57 continued to have trust issues which caused anxiety and that the treatment plan was to continue to explore ways that R57 could have more realistic expectations of himself and others. During interview on 01/11/13 at 8:30 a.m., a registered nurse (RN-MDS) verified that ongoing justification was lacking for R57's psychotropic	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 37 medications, and the two mental health providers notes contradicted each other. On 01/11/13 at 9:30 a.m. the consultant pharmacist stated that the psychiatrist did state that R57 was stable, but could see where there could be confusion when the psychologist indicated differently. No further information was provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F 441 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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.The facility has reviewed the infection prevention and tracking policy and procedure, and have a designed RN responsible to maintain the infection prevention and tracking program 2. Designated RN and nursing staff have been educated on facility policies and procedures on infection prevention and tracking program, education will be completed by February 18, 2013	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop, implement, and maintain an infection control program to ensure prevention and recognition of infections within the facility. This had the potential to affect all 44 residents currently residing in the facility. Findings include: Upon review of the infection control logs since December 2011, the following was noted: The log book contained monthly infection control data collection for the months of December 2011, March 2012, June 2012, July 2012, and October 2012. The form instructed staff to identify resident name, room number, infection site, organism cultured, antibiotic type, stop date, if the infection was present on admission, and any precautions needed. For all five months provided, the infection control data was not complete nor was there any analysis of the data to determine any pattern or trends.	F 441	3. Audits will be performed on antibiotic usage and transmission based precautions. These audits will be conducted monthly for 3 months. 4. The administrator or designee will audit minutes of the committee meetings to assure the action plans and facility quality indicators are being implemented. 5. The data collected will be brought to the QA Committee The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: February 19, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 39 During interview on 01/10/13 at 3:46 p.m. the assistant director of nursing (ADON), who was also the infection control nurse, stated the infection control program was not current. The ADON stated she was currently trying to go back and update the infection control program but was only in the month of October, which is the month she started with the infection control program. The ADON verified there was no current infection control program in the facility, which included tracking of resident or employee infections and also verified it had not been up to date when she took over the infection control program. Review of the facility policy titled Infection Control Program dated 1/10, indicated "The infection Prevention/Control program exists to assure a safe, sanitary and comfortable environment for residents, staff and visitors. The program goals helps prevent the development and transmission of disease and infection...The early detection, prevention and management of infections are accomplished through effective oversight of the Infection Prevention/Control program. Essential functions include the following...To provide program oversight including planning, organizing, implementing, operating, monitoring. To maintain all of the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. To plan organize, implement, operate and maintain all of the program elements...The establishment of surveillance standards and frequency, including both process and outcome surveillance, monitoring of practice, data analysis, documentation and communicable diseases reporting. The development of the education component including the training in infection	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 40 prevention and control practices that ensure compliance. The conduct of antibiotic review including a review of data to monitor the appropriate use of antibiotics in the resident population to limit the development of Multiple Drug Resistant Organism (MDROs)." Also included in the policy, under Role of the Infection Preventionist (IP): "Responsibilities include...Collects and analyzes infection data and trends and provides this information to nursing staff, health care practitioners, the Infection Prevention Committee and Quality Assurance Committee. Consults on on infection risk assessment, prevention, and control strategies including transmission based precautions and isolation." The policy also included the Surveillance Program Activities, listing "Develops standardized definitions and listings of the symptoms of infections. Uses surveillance tools including infection surveys and data collection templates. Performs environmental surveys, and identifies resident population at risk for infection. Identifies the processes or outcomes selected for surveillance. Completes statistical analysis of data that can uncover an outbreak. Communicates the results of surveillance activities to facilitate monitoring of residents. Implements elements of both Process and Outcome Surveillance...Collecting/documenting data on individual cases...Completes the Antibiotic Review for the Infection Control Program." No further information provided.	F 441		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 520 — Continued From page 41

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to provide documentation that the quality assurance (QA) committee actively met on a quarterly basis and failed to ensure physician involvement at these quarterly meetings. This had the potential to affect all 44 residents that are currently residing in the facility.

Findings include:

Review of the facility QA attendance logs

F 520

F 520

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. The facility has an active QA Committee with all required membership.
2. The QA committee will implement active quality improvement programs and will implement and develop appropriate plans of actions for these programs.
3. All staff will be educated regarding the QA Committee and its activities by February 18, 2013.
4. The administrator or designee will audit minutes of the committee meetings to assure the action plans and facility quality indicators are being implemented.
5. The data collected will be brought to the QA Committee The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies.

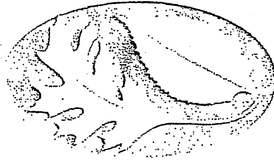
Completion date: February 19, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	01/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 42 indicated that the facility QA committee did not meet quarterly. The log identified meeting dates which included 04/17/12 and 07/17/12, and a list of attendees but no indication that a physician was present at the meetings. During an interview with the administrator on 01/11/13 at 10:55 a.m., she indicated they did conduct an October, 2012 QA meeting but could not provide any meeting minutes nor the list of attendees. She further stated that the medical director was not at the October meeting. She stated she could not verify if a physician was present at the 04/17/12 and 07/17/12 QA meetings as she has been the administrator at this facility only since September 20, 2012, further stating that "QA is an issue, it is my goal to get a good process in place."	F 520		

Sterling Park



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.
3. Resident incidents and suspected abuse will be reported to DNS/Administrator immediately
4. 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	Commons	Park Gardens
(Skilled Care)	(Assisted Living)	(Independent Living)
142 N. 1st Street	35 1st Avenue N.	114 N. 1st Street
Waite Park, MN 56387	Waite Park, MN 56387	Waite Park, MN 56387
320-252-9595	320-252-7224	320-252-7224
Fax: 320-252-9216	Fax: 320-252-5629	Fax: 320-252-5629

1/27/14

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

RECEIVED JAN 21 2014 MN Dept of Health

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	245375		12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended recertification survey was conducted by the Minnesota Department of Health on December 16, 17, 18, 19, and 20th, 2013. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157	F 157 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	1/27/14 See addendum

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 1.17.14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: R50 had symptoms of weight gain, dyspnea and edema. The facility did not notify the physician about these symptoms. 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 (CHF). The History and Physical revealed R50 was hospitalized secondary to recurrent falls, increasing weakness and confusion. It also	F 157	1. 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 will be completed if change noted per change in condition guidelines. 2. Resident #48 had blood pressure monitoring every 2 hours from 12/20/13 through 12/26/13 with no significant elevated blood pressures noted. 2. Progress noted will be reviewed by DNS or designee 5 times per week for 4 weeks. 3. Nursing staff education will be completed by January 24, 2014 on policy and procedure for change in condition and notification of physician. 4. The DNS and/or her designee will conduct audits weekly on any residents with a change in condition. 5. All incident reports will be reviewed by DNS, ED and/or designee post incident for discrepancies in vital signs and injury. 6. 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 Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

indicated her weight was 105 pounds (lbs) on admission to the hospital and 108 lbs on 11/10/13. R50's hospital discharge orders dated 11/11/13, indicated she received atenolol 50 milligrams (mg) and diovan for hypertension. The discharge orders instructed to "call your physician if you gain 3 [three] pounds or more over night, or gain 5 [five] pounds in a week..." The orders also directed a referral on 11/20/13, for a follow-up appointment with her physician.

R50's current care plan dated 11/27/13, identified a problem of hypertension and received anti-hypertensive medications (blood pressure medications). The plan instructed staff to notify her medical practitioner of any signs or symptoms of malignant hypertension including the following: headache, visual problems, confusion, and difficulty breathing. The care plan did not indicate R50 had a history of congestive heart failure and to monitor for fluid retention and weight gain.

Review of the facilities Weights and Vitals Summary revealed the following weights:
11/12/13 118 lbs (up ten lbs (pounds) from hospital discharge weight on 11/11/13)
11/16/13 119 lbs
11/19/13 119 lbs

On 11/20/13, R50's had a scheduled follow up physician visit from her hospitalization on 11/20/13, nine days post hospital discharge. The 11/20/13 office visit noted indicated R50's weight was 117 lbs. The physician commented R50 was up ten lbs and had dyspnea (difficulty breathing) and lower extremity edema. The physician ordered hydrochlorothiazide 25 mg daily (used to treat high blood pressure and edema).
When interviewed on 12/19/13, at 2:50 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

assistant director of nursing (ADON) stated R50 should have had continued monitoring of symptoms for congestive heart failure and been placed on an edema measurement flow sheet. She stated the physician should have been made aware of the residents weight gain on 11/12/13. The ADON verified this had not occurred for R50 and should have.

Even though R50 had symptoms of dyspnea and lower extremity edema with a ten lbs weight gain, the facility failed notify R50's practitioner of this change in her condition.

An undated Change in Condition, When to Report to the MD/NP/PA form provided by the facility, directed weight gain associated with respiratory symptoms, or weight gain of three lbs in one day or five lbs in one week were to be reported to the medical practitioner.

Based on interview and document review, the facility failed to ensure a physician was notified of multiple falls with head injury, and elevated blood pressures, which required physician intervention for 1 of 5 residents (R48) reviewed for falls. The facility also failed a physician was notified of symptoms of congestive heart failure, for 1 of 4 residents (R50) reviewed for nutrition.

Findings include:

R48 had elevated blood pressures, multiple head injuries, and abnormal neurological assessments. The facility failed to follow up on these concerns, or notify the physician of them.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4	F 157		

R48's admission Minimum Data Set (MDS) dated 10/18/13, included diagnoses of hip fracture, hypertension (elevated blood pressure), and dementia. The MDS indicated R48 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL's), and had fallen prior to admission.

R48's care plan dated 10/24/13, included hypertension (high blood pressure) as a focus, and directed staff to, "Observe/document/report to medical practitioner PRN [as needed] and s/sx [signs or symptoms] of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea)."

R48's physician orders dated 12/2/13, included three medications to control hypertension: Accupril 20 mg (milligrams) daily; Cozaar 60 mg daily, and Toprol XL 100 mg daily.

R48's Resident Incident Report dated 10/27/13, indicated she had fallen in her room at 11:25 a.m. Blood pressures at the time of the fall were documented as: lying 203/82 mm (millimeters) hg (mercury) and sitting 167/76 (normal blood pressure 120/80). The next documented blood pressure (183/76) was located in R48's electronic record under Progress Notes dated 10/28/13, at 5:07 a.m. R48's blood pressure remained elevated more than 17 hours after the fall. There was no evidence in R48's medical record to indicate her physician had been notified of the elevated blood pressures or of the drop in blood pressure between lying and sitting.

R48's Resident Incident Report dated 11/2/13, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5	F 157		

12:00 a.m. indicated a second fall had occurred, with a blood pressure of 215/81 noted at the time of the fall. R48 hit her head during the fall and a Neurological Assessment Flow Sheet was initiated, which included frequent blood pressure checks during the 24 hours following the fall. In addition, the Neurological Assessment Flow Sheet indicated R48 had complained of head pain on 11/2/13, at 12:05 a.m., and again at 3:50 a.m. The final blood pressure check on 11/3/13, at 12:30 a.m. was 176/70. The next documented blood pressure (187/78) was located under Vital Signs in the electronic record dated 11/5/13, at 10:29 a.m. R48's blood pressure had remained elevated three days after the fall. There was no evidence in R48's medical record that the physician had been notified of her elevated blood pressure or of the head pain after hitting her head.

R48's Resident Incident Report dated 11/8/13, at 12:30 a.m. indicated R48 had fallen a third time. During this fall, R48 hit her head and sustained a three centimeter (cm) by four cm hematoma (large collection of blood under the skin) to the back of her head. R48's blood pressure at that time was 181/84 sitting and 199/103 lying. A Neurological Assessment Flow Sheet was initiated, dated 11/8/13, and blood pressure checks were completed every four hours for 24 hours. At 4:00 a.m. her blood pressure remained elevated at 199/75. The Neurological Assessment Flow Sheet indicated R48's pupils had been equal round and reacted to light until 8:00 a.m. at which time they were documented as 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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6	F 157		

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. 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, "Pupils 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 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 needed]." The blood pressures recorded were between 113/61 to 183/96. There was no evidence the NP or physician had been notified of R48's elevated blood pressures at the time of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 7 falls on 10/27/13, 11/2/13, 11/8/13, or 11/13/13. R48's NP Nursing Home Rounds report dated 11/22/13, included a physical exam. The NP noted, "I do not have weights or vital signs to review, but I am not made aware of any problems." The NP also noted under Assessment, "Hypertension, but I am not aware of any problems." R48's Resident Incident Report dated 11/24/13, at 10:25 p.m. indicated R48 had fallen a fifth time. The report noted R48 "bumped" her head during the fall. R48's blood pressure at that time was recorded as 210/83 sitting. A Neurological Assessment Flow Sheet was initiated, with blood pressures recorded between 113/61 and 200/83 over the 24 hours following her fall. R48's pupils were recorded as either non-reactive or sluggish. A Centracare Clinic Fax was sent to the physician describing the fall, but noted only a blood pressure reading of 161/66. There was no evidence the physician had been notified of the 210/83 and 200/83 readings, or the non-reactive or sluggish pupils. R48's Nursing Home Rounds by the physician dated 12/11/13, included, "She had a minor fall on November 8, 2013, without sequelae [without complication]; also on October 28, 2013. Under physical exam the note included, "For technical reasons, her blood pressures and weights are not available." There was no evidence the physician was informed of the head injury sustained on 11/8/13, 11/13/13 and 11/24/13 with the symptoms of vomiting, head pain, and abnormal neurological assessments. Also, there was no indication the physician was informed of the elevated blood pressures following each falls	F 157		

F 157 — Continued From page 8 — F 157

which occurred on 10/27, 11/2, 11/8/13, 11/13, and 11/24/13.

When interviewed on 12/19/13, at 2:50 p.m. the director of nursing (DON) stated she expected nursing to recheck R48's blood pressure within a half hour after her first fall on 10/27/13, and to notify the physician if her blood pressure remained elevated. R48's reported head pain noted from her second fall on 11/2/13, and should have reported these symptoms to the physician. R48 had a third fall on 11/8/13, the DON stated nursing should have notified R48's physician about the change in her pupil reaction, headache, vomiting, and her family's expectations. R48, fourth and fifth falls which occurred on (11/13/13, and 11/24/13), the DON stated nursing should have notified R48's physician immediately with concerns over high blood pressures and her pupil reaction after the head injury. The DON added that she expected nursing to report elevated blood pressures from all falls to the physician and verified the physician was not notified when these falls occurred. The DON confirmed that nursing should also have made R48's NP and physician aware of any elevated blood pressures during their nursing home visits on 11/22/13, and 12/11/13, respectively.

An undated facility policy for Change in Condition, When to Report to the MD (medical doctor) /NP/PA (physician's assistant) directed staff to report any systolic (heart contraction) blood pressures over 210, diastolic (heart relaxation) over 115 immediately, and diastolic routinely over 90 the next day. The form also indicated the need to contact the physician if the resident sustained a contusion associated with a recent fall with no other complications, and to send the

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 9 resident to the emergency room immediately following a fall with a head injury.	F 157	F 164	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures	F 164	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident #47is being trialed with wearing shorts and if resident is not in agreement, facility will continue to trial different options for privacy, while honoring resident right to choice. 2. Care sheets have been updated to reflect resident #47 dressing preferences 3. Nursing staff education will be completed by January 24, 2014, to include resident bill of rights regarding privacy, dignity and resident choice 4. The DNS and/or her designee will conduct two audits weekly for one month and then once weekly for two months for dignity and resident choice.	

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 10 to ensure personal privacy for 1 of 1 resident (R47) reviewed for personal privacy. Findings include: R47's admission Minimum Data Set (MDS) dated 7/17/13, included a diagnosis of quadriplegia. The MDS identified R47 had no cognitive impairment, required an in indwelling supra-pubic catheter, a gastric (PEG) feeding tube, and received total assistance from staff for all daily needs. On 12/17/13, during continuous observation between 10:27 a.m. and 12:06 p.m., R47 was observed in his resident room, lying on the bed. The door was noted as wide- open, with R47's bed positioned by the window and the blinds partially open. R47 was dressed in a T-shirt and was positioned with his knees slightly bent, supported by a pillow. R47's feet and knees were covered by a blanket; however, his mid-section was uncovered, exposing R47's incontinent brief, as well as his catheter tubing. During this time, a nursing assistant (NA), maintenance person, and nurse were observed to walk past R47's open door. None of the staff intervened to ensure R47 was provided with personal privacy. On 12/18/13, at 6:40 a.m. R47 was observed from the sidewalk outside the facility, through the window of his resident room. R47 was dressed in a T-shirt, with a blanket covering his lower legs and feet. R47's mid-section was left uncovered, exposing his incontinent brief. On 12/18/13, at 6:50 a.m. R47 was observed from the hallway, with the door wide-open, and his incontinent brief exposed. The window blinds for the window next to R47's bed were completely	F 164	5. 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 Committee will make the decision/recommendation regarding any follow-up studies. Completion date: January 24, 2014	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 11	F 164		

open. The window faced a busy street and cars were observed driving by. During this observation, numerous NAs, physical therapy personnel, and a visitor were noted to pass by R47's open door. None of the staff intervened to ensure R47 was provided with personal privacy.

On 12/18/13, at 9:44 a.m. R47's door was again observed to be wide-open, with his incontinent brief exposed to anyone who passed by his room.

Review of R47's care plan, last updated on 10/16/13, addressed R47's intact cognition and his ability to make decisions. The care plan noted, "[R47] Does not care if visitors, staff, or other residents see him lying in bed without covers, leaving brief and legs and catheter bag exposed, he was more comfortable uncovered." The care plan did not direct staff to pull a privacy curtain to maintain personal privacy for R47.

During an interview on 12/19/13, at 8:20 a.m. NA-B stated, "We try to keep [R47] covered," close the privacy curtain in his room round his bed and have the drapes partially drawn so he was not exposed. NA-B explained R47 could be difficult to work with and did not want his room door closed. NA-B added, "[R47] does not care ..." that he could be seen from the hallway. NA-B further added R47 was often reminded the room was on the ground floor with a window and he could be seen from the outside. NA-B stated, "No resident, staff, or visitors," should have been able to walk by a room, and see someone, including R47, unclothed, with his incontinent brief exposed.

In an interview on 12/18/13, at 11:16 a.m. licensed practical nurse (LPN)-A stated when

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 12 staff worked with R47 they kept the room door closed, but R47 often refused to keep the door closed, even when wearing next to nothing. LPN-A stated, "I personally would not like..." to see residents exposed or receiving cares in open view. She added, "That's not right." During interview on 12/19/13, at 10:20 a.m. director of nursing (DON) stated she was aware of the privacy issue with R47. DON acknowledged R47's door was often wide open and he was visible from the hallway or an undraped window to anyone who passed by his door or window. The DON stated the privacy concern for R47 was well documented and added R47's rights and wishes had to be respected. Although R47 was observed multiple times with his incontinent brief exposed with staff walking by the room, made no attempts to ensure R47's personal privacy. Also, there was no indication the facility provided other measures that could be implemented to ensure R47's personal privacy.	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to initiate efforts to resolve individual resident grievances for 2 of 2 residents (R51 and R6) who had expressed	F 166	F 166 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 13 concerns over long call light wait times and private resident room space being used to store a bed for the facility. Findings include: R51's complaints of untimely call light response times were not effectively addressed by the facility. R51's annual Minimum Data Set (MDS) dated 10/8/13, included a diagnosis of quadriplegia (paralysis of all limbs). R51 was cognitively intact, showed verbal behaviors towards others, required extensive to total staff assistance for all activities of daily living (ADLs), and was always incontinent of bowel and bladder. When interviewed on 12/17/13, at 11:00 a.m. R51 stated she often had to wait for extended periods of time, sometimes up to an hour, when she needed assistance from staff. R51 stated she was paralyzed and unable to do anything for herself. She added, "The aides are always rushed, they say they are working short, it makes me feel bad for needing so much help." R51 stated she had reported her concerns to many nurses and the director of nursing (DON); however, she reported, "[The nurses] just tell me they are not working short ... [The problem] never changes." During a follow-up interview on 12/19/13, at 10:00 a.m. R51 stated she was upset because it took so long for someone to answer her call light. She indicated she sometimes had to wait up to an hour for response to her call light requests. R51 stated the longest wait time was after supper and after midnight until morning. She reported, "The	F 166	1. Resident #51 has been interviewed by DNS and states that call light response time has "gotten much better since the state was here". 2. Resident #6 requested a private room, facility did not have a private room to offer resident #6 and was then offered a semiprivate 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 and this will be reviewed ongoing with resident and again with resident/family at care conference on 1/21/14. Facility will continue to offer resident alternative rooms as the become available. 3. All resident/family grievances/concerns will be followed up on per facility quality improvement policy 4. Education to staff regarding resident grievances and policy will be completed by January 24, 2014 5. The DNS and/or her designee will complete two audits per week for one month then weekly for two months regarding resident grievances/concerns. 6. The data collected will be presented to the QA	

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 14 aides say they are short staffed, and they rush through helping me. I feel bad they are short, but I have to wait to get a drink of water, or get my pad changed." R51 then stated, "Now I know why a baby cries when their diaper is wet" R51 stated she began to "holler" out when she had to wait a long time. She indicated hollering did result in a response from staff, but she was then told she had to be patient because they were working short. R51's call light logs from 11/18/13, through 12/18/13, revealed her call light had been activated for over 25 minutes on 18 occasions. All of these times were between 5:55 p.m. and 12:15 a.m. On 12/6/13, at 7:11 p.m. her call light wait was 61.2 minutes. On 12/8/13, at 7:02 p.m. her call light wait time was 58.5 minutes. R51's care plan dated 10/9/13, indicated she was at high risk for developing pressure ulcers related to urinary incontinence and dependence upon staff for cares. The care plan also indicated behavior problems related to calling out for assistance after she activated her call light. The care plan directed staff to, "Monitor call light times as appropriate." When interviewed on 12/19/13, at 8:30 a.m. the DON explained the care plan instruction of, "Monitor call light times as appropriate," meant that if R51 complained, she reviewed the call light logs for long wait times and checked with staff to see why the waits were so long. Though she confirmed she was aware R51 had expressed concerns of long call light response times, the DON had not checked the call light logs recently. The DON had not implemented any actions in effort to resolve long call light waits for R51.	F 166	Committee by the DNS. 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. Completion date: January 24, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ________ B. WING ________	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 15	F 166		

R6 was in a private resident room and had requested an extra bed be removed from her room. The facility did not remove the bed and stated the bed needed to be "stored" in her room.

R6's quarterly MDS dated 10/15/13, identified her cognition was intact and she required extensive staff assistance for all ADLs.

On 12/16/13, at 4:20 p.m. R6's room was observed to have two-single beds. One bed was positioned against the wall by her window. The bed was stacked with a pile of papers, clothes, and miscellaneous items.

During interview on 12/16/13, at 4:30 p.m. R6 stated she was happy she had a private room at the facility; however, she revealed that she had asked the facility several times to remove the other single bed out of her room so she had more space to put her belongings. R6 stated she was told they (the facility) did not have another place to store the bed, but it would be removed once another place to put the extra bed could be located. R6 stated she had asked several months ago to have the extra bed removed and she continued to receive the same response from the facility regarding their lack of storage space to remove the bed.

R6's Progress Note dated 11/21/13, indicated, "Social services met with [R6] today. She was pleasant and stated satisfaction with her room... She continued to state a desire to have a private room with only one bed as available. Staff will offer alternative rooms as available and appropriate..."

During interview on 12/17/13, at 12:10 p.m. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 16 stated R6 had spoken to her, "A couple months ago," requesting the spare bed in her private room be removed. DON stated the facility did not have anywhere to store the spare bed so they had just been keeping it in the resident's room. DON verified the facility currently had empty rooms which were not being used by any residents but stated the facility needed to keep those rooms available for any new admissions. DON verified no resolution was really made regarding removing the extra bed. During interview on 12/17/13, at 12:15 p.m. Social Worker (SW)-A stated she was aware R6 wanted the spare bed removed from her room, but the facility was short on storage space and needed to store it in R6's room. SW-A stated she had spoken to R6 and her family members regarding her requests to have the extra bed removed. A facility policy on resolving resident grievances was requested but not provided.	F 166		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	F 225 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 17 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse and neglect were thoroughly investigated, actions were taken to protect residents until an investigation was completed and allegations were reported to the administrator and state agency (SA) immediately for 4 of 7 residents (R6, R32, R48 and R11) reviewed with allegations of abuse or neglect. Findings include: R6 reported to the facility that a staff member had	F 225	1. Resident incidents and suspected abuse will be reported to DNS/ED within a timely matter. 2. All incident reports will be scanned emailed to DNS/ED/nurse consultant an/or designee within a timely manner for review when unavailable in the building 3. DNS/ED or designee will determine if incident/allegation is reportable to state agency and initiate investigation as felt necessary. 4. Education regarding vulnerable adult policy will be provided to all staff by January 24, 2014. 5. The ED/DNS and/or her designee will audit all incident reports and grievance/concern forms for one month. 6. The data collected will be presented to the QA Committee by the ED. 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. Completion date: January 24, 2014	

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 18 been rough with her. R6 requested that staff member no longer provide cares for her. However, the facility did not investigate the allegation of abuse, implement efforts to protect R6 until the allegation was investigated, or immediately report the incident to the SA. R6's quarterly Minimum Data Set (MDS) dated 10/15/13, identified her with no cognitive impairment and she required extensive from staff assistance for all activities of daily living (ADLs). During interview on 12/16/13, at 4:20 p.m. R6 stated a "couple weeks" ago she had told the social worker that nursing assistant (NA)-A was rough with her when providing cares and she did not want her providing cares to her anymore. R6 stated NA-A continued to take care of her "at night." R6 stated the facility told her they had spoken to NA-A, who denied the allegation, so they continued to let NA-A care for her. During interview on 12/16/13, at 4:30 p.m. family member (FM)-J stated she had spoken to registered nurse (RN)-A about NA-A being rough with R6 and did not want NA-A to provide cares for the resident any longer. FM-J stated no one had spoken to her regarding her concerns with NA-A, and she continued to provide cares to the resident. During interview on 12/17/13, at 12:05 p.m. director of nursing (DON) stated FM-J left her a voice mail on 11/30/13, regarding concerns of NA-A being rough with R6. The DON stated they interviewed R6 and she stated she did not mind NA-A working with her and she did not feel afraid. DON also stated she had not heard any other reports from staff regarding NA-A or complaints	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 19	F 225		

from family or residents about her. DON verified the allegation of staff abuse were not thoroughly investigated or reported to the SA.

During interview on 12/17/13, at 8:10 p.m. RN-A stated FM-J came to her "about a month ago" and said that NA-A was "rough with [R6] last night." RN-A stated she talked to NA-A and she stated she was not rough with the resident. RN-A did not report this to anyone or write up an investigation because she didn't have a "specific complaint."

Although R6 and FM-J made specific complaints about NA-A being rough with the resident, this was not thoroughly investigated or reported to the SA, nor did the facility ensure R6's request of no longer receiving care from NA-A was honored.

R32 had several falls when the care plan was not being followed. The falls were not investigated or reported to the SA as alleged neglect.

R32's quarterly MDS dated 9/26/13, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs except eating, and was frequently incontinent of bladder. R32's care plan dated 10/29/13, instructed, "[R32] is at risk for falls related to history of Parkinson's with behavioral disturbance, poor safety decisions, and need for assist with ADLs and toileting. Had fall on 5/1/13 with right hip fracture and pelvic ring fracture... pelvic fracture 9/20/13 due to fall 9/17/13." The facility interventions were "Anti-rollback mechanism to wheelchair to prevent any falls... has asked not to be offered toileting more than upon rise, HS (hour sleep), before meals, and with staff assisted

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 20 repositioning to prevent falls... family is opposed to TABS alarm placement for fall notification... room close to nursing station to facilitate more frequent monitoring for self-transfers... non-slip product on top of wheelchair cushion to prevent sliding out of wheelchair, remove wheelchair pedals when not being propelled by staff... would like phone placed on bed after bed is made in morning to ease access... ensure remote is within her reach when in her room..." The current NA worksheet dated 12/17/13, instructed staff to "assist resident to lie down when displaying poor posture and between meals... fall prevention: If walking independently provide gentle cues. Do not force to sit in wheelchair. If in room alone assure over bed table over legs, use side cushion when leaning. Reposition every 2-3 [two to three] hours." Review of R32's incident reports identified staff were not consistently following the care plan were as follows: 3/4/13- 9:20 p.m. "Resident was found on the floor of her room next to her closet. It appeared that resident had been in her wheelchair 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 resident's wheelchair to prevent her from sliding out of wheelchair in the future." During interview on 12/17/13, at 11:00 a.m. DON stated the Dysum non-slip pad was supposed to be in the resident's wheelchair as that was the intervention implemented after the prior fall on 2/18/13. DON stated there was no further investigation as to why the Dysum was not in R32's wheelchair according to the plan of care nor was the potential neglect of healthcare reported to the SA.	F 225		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 21 3/13/13- 3:15 p.m. "Resident was found in her room on her hands and knees. She stated she gently slipped off her wheelchair and fell to her knees when she was trying to pick something up..." There was no indication if the anti-slip cushion or Dysum was in the wheelchair. The summary of the fall indicated, "On 3/14/13, [Nurse Practitioner (NP)] was here for rounds and ordered a chest X-ray and various other orders due to increased confusion and decreased breath sounds. This revealed that resident had 4 [four] broken ribs on the left side, possibly the cause of increased leaning and confusion due to pain. This is being addressed and monitored." Review of the chest X-ray dated 3/14/13, indicated R32 had "fracture of the left second through sixth ribs." Handwritten on the bottom of the X-ray by an unknown facility nurse on 3/14/13, a message was left with R32's physician and NP. On 3/15/13, it was written the facility had faxed a copy of the results to R32's physician and NP. There was no investigation in the record that identified how R32 received four fractured ribs on the left side, nor was the SA notified of the unknown source of the fracture. During interview on 12/17/13, at 11:00 a.m. the DON stated after the fall on 3/13/13, the NP saw R32 and ordered a chest X-ray related to decreased breath sounds. She stated the chest X-ray revealed R32 had four broken ribs; however, the facility had no investigation or communication with the NP or the physician regarding R32's broken ribs. DON stated there was no further investigation of the broken ribs nor was there any further information regarding the anti-slip pad not being in R32's wheelchair. DON verified this should have been reported to the SA and it was not. 3/18/13- 5:00 p.m. "Resident was found lying on	F 225		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING B. WING	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 22 her left side on the floor of her room...Last time toileted was 'after lunch.' Resident was dry at time of fall." During interview on 12/17/13, at 11:00 a.m. DON stated she was not sure the specific time R32 had last been toileted before the fall on 3/18/13, as this was not part of the initial incident report investigation. DON verified there was not a complete investigation of the fall nor was this reported to the SA related to the possible neglect of healthcare. 3/31/13- 3:45 p.m. "Resident was found sitting on the floor in her room next to her wheelchair and over-turned tray table... Assessed room for placement of items resident may be reaching for, rearranged appropriately." During interview on 12/17/13, at 11:00 a.m. DON stated she did not know what the resident was attempting to do nor was she sure how the resident's room was arranged prior to the fall as this wasn't part of the investigation. The DON stated education was done with staff to ensure R32's call light was within reach, however, she was unable to verify why this education was done as she was not sure if the resident had her call light near her at the time of her fall. DON verified this was not thoroughly investigated or reported to the SA related to not following R32's care plan. 5/1/13- 6:45 a.m. "Resident was found lying on her right side, up against the closet. Resident was unable to report what occurred or what she was trying to do prior to fall... last toileted at 5:30 a.m. and was continent at time of fall... Resident complained of right hip pain." The facility contacted the physician to obtain an X-ray which displayed a hip fracture and pelvis displacement. R32 was transferred to the hospital for surgery. The facility intervention after this fall was "assure resident is set up with appropriate items she may	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 23	F 225		

need (snack, magazine, etc.)."
The X-ray results dated 5/1/13 identified R32 had a "right intertrochanteric hip fracture with up to roughly 6 mm (millimeters) of displacement... Fractures of the right superior and inferior pubic rami are again noted. There is increased displacement compared to prior exam. An associated sacral ala fracture is suspected but not identified with certainty..."
During interview on 12/17/13 at 11:00 a.m. DON stated the intervention was to make sure staff kept the resident's 'items' within reach. DON stated the investigation did not include where items were placed in the residents room when she fell on 5/1/13 and the fall with injury was not reported to the SA.
6/1/13- 11:00 a.m. "Resident was found by staff sitting on her bottom near the bathroom, leaning on her elbows. Resident attempted to self-transfer and stated she slid very slowly to the floor...Resident was last toileted at 9:00 a.m., and was incontinent at time of fall... Resident is to be offered toileting every hour, re-education was provided to NA." The investigation did not identify where the resident slid from and if the anti-slip cushion was in the resident's wheelchair.
During interview on 12/17/13, at 11:00 a.m. DON stated she was not sure if the resident's anti-slip Dysum was on her wheelchair cushion as that was not part of the fall investigation. DON verified this should have been investigated to ensure the plan of care was being followed. This was not reported to the SA.
6/16/13- 5:15 p.m. "Resident was found lying on her right side with legs bent to her chest. Was attempting to reach for something when she slid out of her wheelchair. Resident stated she was going to throw a piece of paper away and slid out of wheelchair. Was complaining of severe pain

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 24 from left hip to upper right side of her body... ambulance was called... no fractures or other injuries. Educated family on use of anti-roll back brakes for the wheelchair which were applied at this time." During interview on 12/17/13, at 11:00 a.m. DON stated anti-lock brakes were added to R32's wheelchair after the fall on 6/16/13. DON stated she was not sure if the anti-slip Dysum was in the residents chair as this was not part of the fall investigation. This was not reported to the SA. 9/17/13- 4:40 p.m. "Resident was found on the floor by the NA. She was lying on her back and grasping her left hip, groin area and expressing severe pain...ambulance was contacted and resident was transported to the St. Cloud hospital. Prior to her fall activity staff had reported that she found resident standing in her room. She entered the room and had resident sit back in her wheelchair, and asked if there was something the resident needed. Resident pointed and stated, 'I need that over there,' though nothing was noted to be present...When found on the floor nurse asked what she was trying to do and resident stated she was trying to 'get out of here'... Family had requested that no alarms be placed on resident as to not limit her mobility...Resident has anti-roll back brakes applied to her wheelchair, toileting plan in place and followed correctly." Resident returned to the facility from the hospital on 9/19/13. Review of a Trauma Admission note dated 9/17/13, indicated R32 had a pelvis X-Ray which identified, "Evidence of old right hip fractures with new [acute] fractures of the left inferior pubic ramus and parasymphyseal region of the left pubic bone." R32 was admitted to the hospital. During interview on 12/17/13 at 11:00 a.m. DON stated the facility did not put new interventions in	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. "Resident 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 the residents care plan, the falls were not thoroughly investigated or reported to the SA. R48 had fallen multiple times while her care plan was not followed by staff. This neglect of health care 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.	F 225		

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 26	F 225		

R48's care plan dated 10/24/13, included, "[R48] is at risk for falls r/t [related to] history of, cognitive loss with impaired decision making, incont [incontinent], new to environment, daily analgesia use, and osteoporosis." The care plan directed staff to ensure her call light was in reach, her bed kept in a low position, her needs anticipated, and to attempt to determine the cause of any falls.

R48's Resident Incident Report dated 10/27/13, at 11:25 a.m. indicated R48 had fallen. The fall investigation report indicated she had slipped out of bed, and staff should now leave the bed at the "appropriate height so resident is not trying to stand up from low bed position, and to assure walker in reach so if resident attempts to get up she is safer." This new approach was added to the care plan on 10/27/13.

R48's Resident Incident Report dated 11/2/13, at 12:00 a.m. indicated R48 had fallen, her bed had been in the lowest position, not the "appropriate height" as indicated. The report indicated this was not reported to the SA because it was not a reportable incident. The report also indicated the administrator had not been notified until 11/5/13, three days later. When interviewed on 12/19/13, at 2:50 p.m. the DON stated R48's care plan of bed at appropriate height and walker by bed, had not been followed, R48 fell attempting to get out of a low bed, this should have been reported to the administrator and SA immediately, but had not.

R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. indicated R48 had fallen while trying to get out of bed. The Incident Investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 27	F 225		

indicated her walker had not been in reach. Staff were re-educated on leaving walker within reach. The incident report indicated the administrator had not been notified until 11/15/13, two days later, and the SA had not been notified because it was not a reportable incident of abuse or neglect. When interviewed on 12/19/13, at 2:50 p.m. the DON stated the administrator and SA should have been notified immediately, because the care plan had not been followed and R48 had suffered a fall.

R48's Resident Incident Report dated 12/10/13, at 9:20 a.m. indicated R48 had been left on the toilet, in the bathroom alone. The Incident Investigation indicated staff were re-educated on not leaving R48 unattended on the toilet due to impulsive behavior. The incident was not reported to the administrator until 12/11/13, the next day, and had not been reported to the SA.

When interviewed on 12/19/13, at 2:50 p.m. the DON stated it is the facility policy not to leave unsteady or cognitively impaired residents alone in the bathroom. She had re-educated the nurse aide responsible at the time of the fall. The DON stated this should have been reported to the administrator and the SA immediately.

R11's care plan was not followed when R11 fell while left unattended on a commode in her room. The incident was not immediately reported to the administrator or the SA.

R11's Resident Incident Report dated 11/4/13, at 5:00 a.m. indicated she was found on the floor in her room. She had been on the commode and was found ten minutes later on the floor. The report indicated the immediate intervention of,

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 28	F 225		

"Educated staff to not leave resident unattended on commode." The report indicated it was not a reportable (abuse or neglect) issue and the administrator was not notified about the incident until the following day, on 11/5/13.

R11's annual MDS dated 10/16/13, indicated she was moderately cognitively intact and required extensive assistance with transfers, ambulation and bed mobility. The MDS also indicated R11 had no falls since the prior assessment on 10/9/13, and she was frequently incontinent of bladder.

R11's care plan dated 10/13/16, indicated she was at moderate risk for falls related to being unaware of her safety needs, short term memory loss, psychotropic medication use, gait/balance problems, bladder urgency with incontinence, attempts to self-transfer and her need for assist of one with transfers and toileting.

During interview 12/19/13, at 10:30 a.m. the DON verified R11 had fallen as a result of staff not following her care plan of not leaving her unattended on the commode. The DON stated she did not notify the administrator or the SA immediately because she was not aware it was a reportable incident.

A policy entitled Reporting of Maltreatment Policy and Procedure, dated 12/11/11, defined neglect as, "Failure to provide goods and services necessary to avoid physical harm..." Under Reporting of Accidents and Incidents, included, "[The facility] shall ensure that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 29 prevent accidents." The policy further indicated after any allegation of abuse, neglect, or unexplained injury, the alleged perpetrator would be re-assigned, placed under direct supervision or suspended pending investigation for the resident's protection. The administrator and SA would be contacted immediately.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an abuse prohibition policy which included thorough investigations of allegations of abuse and neglect, actions taken to protect residents until investigations of abuse and neglect allegations were complete, and immediate reporting of allegations to the administrator and state agency (SA), for 4 of 7 residents (R6, R32, R48 and R11) reviewed with allegations of abuse or neglect. Findings include: A facility policy entitled Reporting of Maltreatment Policy and Procedure, dated 12/11/11, defined neglect as, "Failure to provide goods and services necessary to avoid physical harm..." Under Reporting of Accidents and Incidents, included, "Sterling Park Health Care Center shall ensure	F 226	F 226 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident incidents and suspected abuse will be reported to DNS/ED within a timely matter. 2. All incident reports, including medication errors will be reviewed by the DNS and ED /or designee for possible Vulnerable Adult reporting according to state and federal guidelines. 3. Education regarding vulnerable adult policy will be provided to all staff by January 24, 2014. 4. The ED/DNS and/or her designee will audit all	

TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 226 Continued From page 30
that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents." The policy further indicated after any allegation of abuse, neglect, or unexplained injury, the alleged perpetrator would be re-assigned, placed under direct supervision or suspended pending investigation for the resident's protection. The administrator and SA would be contacted immediately.

R6 reported to the facility that a staff member had been rough with her. R6 requested that staff member no longer provide cares for her. However, the facility did not investigate the allegation of abuse, implement efforts to protect R6 until the allegation was investigated, or immediately report the incident to the SA in accordance with the facility's abuse prohibition policy.

R6's quarterly Minimum Data Set (MDS) dated 10/15/13, identified her with no cognitive impairment and she required extensive from staff assistance for all activities of daily living (ADLs).

During interview on 12/16/13, at 4:20 p.m. R6 stated a "couple weeks" ago she had told the social worker that nursing assistant (NA)-A was rough with her when providing cares and she did not want her providing cares to her anymore. R6 stated NA-A continued to take care of her "at night." R6 stated the facility told her they had spoken to NA-A, who denied the allegation, so they continued to let NA-A care for her.

During interview on 12/16/13, at 4:30 p.m. family member (FM)-J stated she had spoken to

F 226

incident reports and grievance/concern forms for one month.

5. The data collected will be presented to the QA Committee by the ED. 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.

Completion date: January 24, 2014

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	245375		12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 31 registered nurse (RN)-A about NA-A being rough with R6 and did not want NA-A to provide cares for the resident any longer. FM-J stated no one had spoken to her regarding her concerns with NA-A, and she continued to provide cares to the resident. During interview on 12/17/13, at 12:05 p.m. director of nursing (DON) stated FM-J left her a voice mail on 11/30/13, regarding concerns of NA-A being rough with R6. The DON stated they interviewed R6 and she stated she did not mind NA-A working with her and she did not feel afraid. DON also stated she had not heard any other reports from staff regarding NA-A or complaints from family or residents about her. DON verified the allegation of staff abuse were not thoroughly investigated or reported to the SA. During interview on 12/17/13, at 8:10 p.m. RN-A stated FM-J came to her "about a month ago" and said that NA-A was "rough with [R6] last night." RN-A stated she talked to NA-A and she stated she was not rough with the resident. RN-A did not report this to anyone or write up an investigation because she didn't have a "specific complaint." Although R6 and FM-J made specific complaints about NA-A being rough with the resident, this was not thoroughly investigated or reported to the SA, nor did the facility ensure R6's request of no longer receiving care from NA-A was honored. R32 had several falls when the care plan was not being followed. The falls were not investigated or reported to the SA as alleged neglect as per the facility policy.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 32 R32's quarterly MDS dated 9/26/13, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs except eating, and was frequently incontinent of bladder. R32's care plan dated 10/29/13, instructed, "[R32] is at risk for falls related to history of Parkinson's with behavioral disturbance, poor safety decisions, and need for assist with ADLs and toileting. Had fall on 5/1/13 with right hip fracture and pelvic ring fracture... pelvic fracture 9/20/13 due to fall 9/17/13." The facility interventions were "Anti-rollback mechanism to wheelchair to prevent any falls... has asked not to be offered toileting more than upon rise, HS (hour sleep), before meals, and with staff assisted repositioning to prevent falls... family is opposed to TABS alarm placement for fall notification... room close to nursing station to facilitate more frequent monitoring for self-transfers... non-slip product on top of wheelchair cushion to prevent sliding out of wheelchair, remove wheelchair pedals when not being propelled by staff... would like phone placed on bed after bed is made in morning to ease access... ensure remote is within her reach when in her room..." The current NA worksheet dated 12/17/13, instructed staff to "assist resident to lie down when displaying poor posture and between meals... fall prevention: If walking independently provide gentle cues. Do not force to sit in wheelchair. If in room alone assure over bed table over legs, use side cushion when leaning. Reposition every 2-3 [two to three] hours." Review of R32's incident reports identified staff were not consistently following the care plan were as follows: 3/4/13- 9:20 p.m. "Resident was found on the floor of her room next to her closet. It appeared	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 33 that resident had been in her wheelchair 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 resident's wheelchair to prevent her from sliding out of wheelchair in the future." During interview on 12/17/13, at 11:00 a.m. DON stated the dysum non-slip pad was supposed to be in the resident's wheelchair as that was the intervention implemented after the prior fall on 2/18/13. DON stated there was no further investigation as to why the dysum was not in R32's wheelchair according to the plan of care nor was the potential neglect of healthcare reported to the SA. 3/13/13- 3:15 p.m. "Resident was found in her room on her hands and knees. She stated she gently slipped off her wheelchair and fell to her knees when she was trying to pick something up..." There was no indication if the anti-slip cushion or dysum was in the wheelchair. The summary of the fall indicated, "On 3/14/13, [Nurse Practitioner (NP)] was here for rounds and ordered a chest X-ray and various other orders due to increased confusion and decreased breath sounds. This revealed that resident had 4 [four] broken ribs on the left side, possibly the cause of increased leaning and confusion due to pain. This is being addressed and monitored." Review of the chest X-ray dated 3/14/13, indicated R32 had "fracture of the left second through sixth ribs." Handwritten on the bottom of the X-ray by an unknown facility nurse on 3/14/13, a message was left with R32's physician and NP. On 3/15/13, it was written the facility had faxed a copy of the results to R32's physician and NP. There was no investigation in the record that identified how R32 received four fractured ribs on	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 34 the left side, nor was the SA notified of the unknown source of the fracture. During interview on 12/17/13, at 11:00 a.m. the DON stated after the fall on 3/13/13, the NP saw R32 and ordered a chest X-ray related to decreased breath sounds. She stated the chest X-ray revealed R32 had four broken ribs; however, the facility had no investigation or communication with the NP or the physician regarding R32's broken ribs. DON stated there was no further investigation of the broken ribs nor was there any further information regarding the anti-slip pad not being in R32's wheelchair. DON verified this should have been reported to the SA and it was not. 3/18/13- 5:00 p.m. "Resident was found lying on her left side on the floor of her room...Last time toileted was 'after lunch.' Resident was dry at time of fall." During interview on 12/17/13, at 11:00 a.m. DON stated she was not sure the specific time R32 had last been toileted before the fall on 3/18/13, as this was not part of the initial incident report investigation. DON verified there was not a complete investigation of the fall nor was this reported to the SA related to the possible neglect of healthcare. 3/31/13- 3:45 p.m. "Resident was found sitting on the floor in her room next to her wheelchair and over-turned tray table... Assessed room for placement of items resident may be reaching for, rearranged appropriately." During interview on 12/17/13, at 11:00 a.m. DON stated she did not know what the resident was attempting to do nor was she sure how the resident's room was arranged prior to the fall as this wasn't part of the investigation. The DON stated education was done with staff to ensure	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 35 R32's call light was within reach, however, she was unable to verify why this education was done as she was not sure if the resident had her call light near her at the time of her fall. DON verified this was not thoroughly investigated or reported to the SA related to not following R32's care plan. 5/1/13- 6:45 a.m. "Resident was found lying on her right side, up against the closet. Resident was unable to report what occurred or what she was trying to do prior to fall... last toileted at 5:30 a.m. and was continent at time of fall... Resident complained of right hip pain." The facility contacted the physician to obtain an X-ray which displayed a hip fracture and pelvis displacement. R32 was transferred to the hospital for surgery. The facility intervention after this fall was "assure resident is set up with appropriate items she may need (snack, magazine, etc.)." The X-ray results dated 5/1/13 identified R32 had a "right intertrochanteric hip fracture with up to roughly 6 mm (millimeters) of displacement... Fractures of the right superior and inferior pubic rami are again noted. There is increased displacement compared to prior exam. An associated sacral ala fracture is suspected but not identified with certainty..." During interview on 12/17/13 at 11:00 a.m. DON stated the intervention was to make sure staff kept the resident's 'items' within reach. DON stated the investigation did not include where items were placed in the residents room when she fell on 5/1/13 and the fall with injury was not reported to the SA. 6/1/13- 11:00 a.m. "Resident was found by staff sitting on her bottom near the bathroom, leaning on her elbows. Resident attempted to self-transfer and stated she slid very slowly to the floor...Resident was last toileted at 9:00 a.m., and was incontinent at time of fall... Resident is to be	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 36 offered toileting every hour, re-education was provided to NA." The investigation did not identify where the resident slid from and if the anti-slip cushion was in the resident's wheelchair. During interview on 12/17/13, at 11:00 a.m. DON stated she was not sure if the resident's anti-slip dysum was on her wheelchair cushion as that was not part of the fall investigation. DON verified this should have been investigated to ensure the plan of care was being followed. This was not reported to the SA. 6/16/13- 5:15 p.m. "Resident was found lying on her right side with legs bent to her chest. Was attempting to reach for something when she slid out of her wheelchair. Resident stated she was going to throw a piece of paper away and slid out of wheelchair. Was complaining of severe pain from left hip to upper right side of her body... ambulance was called... no fractures or other injuries. Educated family on use of anti-roll back brakes for the wheelchair which were applied at this time." During interview on 12/17/13, at 11:00 a.m. DON stated anti-lock brakes were added to R32's wheelchair after the fall on 6/16/13. DON stated she was not sure if the anti-slip dysum was in the residents chair as this was not part of the fall investigation. This was not reported to the SA. 9/17/13- 4:40 p.m. "Resident was found on the floor by the NA. She was lying on her back and grasping her left hip, groin area and expressing severe pain...ambulance was contacted and resident was transported to the St. Cloud hospital. Prior to her fall activity staff had reported that she found resident standing in her room. She entered the room and had resident sit back in her wheelchair, and asked if there was something the resident needed. Resident pointed and stated, 'I need that over there,' though	F 226		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 37 nothing was noted to be present...When found on the floor nurse asked what she was trying to do and resident stated she was trying to 'get out of here'... Family had requested that no alarms be placed on resident as to not limit her mobility...Resident has anti-roll back brakes applied to her wheelchair, toileting plan in place and followed correctly." Resident returned to the facility from the hospital on 9/19/13. Review of a Trauma Admission note dated 9/17/13, indicated R32 had a pelvis X-Ray which identified, "Evidence of old right hip fractures with new [acute] fractures of the left inferior pubic ramus and parasymphyseal region of the left pubic bone." R32 was admitted to the hospital. During interview on 12/17/13 at 11:00 a.m. DON stated the facility did not put new interventions in 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. "Resident 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 the residents care plan, the falls	F 226		

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 38 were not thoroughly investigated or reported to the SA. R48 had fallen multiple times while her care plan was not followed by staff. This neglect of health care was not reported to the administrator immediately, or to the SA as per the facility's policy. 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. R48's care plan dated 10/24/13, included, "[R48] is at risk for falls r/t [related to] history of, cognitive loss with impaired decision making, incont [incontinent], new to environment, daily analgesia use, and osteoporosis." The care plan directed staff to ensure her call light was in reach, her bed kept in a low position, her needs anticipated, and to attempt to determine the cause of any falls. R48's Resident Incident Report dated 10/27/13, at 11:25 a.m. indicated R48 had fallen. The fall investigation report indicated she had slipped out of bed, and staff should now leave the bed at the "appropriate height so resident is not trying to stand up from low bed position, and to assure walker in reach so if resident attempts to get up she is safer." This new approach was added to the care plan on 10/27/13.	F 226		

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 39 R48's Resident Incident Report dated 11/2/13, at 12:00 a.m. indicated R48 had fallen, her bed had been in the lowest position, not the "appropriate height" as indicated. The report indicated this was not reported to the SA because it was not a reportable incident. The report also indicated the administrator had not been notified until 11/5/13, three days later. When interviewed on 12/19/13, at 2:50 p.m. the DON stated R48's care plan of bed at appropriate height and walker by bed, had not been followed, R48 fell attempting to get out of a low bed, this should have been reported to the administrator and SA immediately, but had not. R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. indicated R48 had fallen while trying to get out of bed. The Incident Investigation indicated her walker had not been in reach. Staff were re-educated on leaving walker within reach. The incident report indicated the administrator had not been notified until 11/15/13, two days later, and the SA had not been notified because it was not a reportable incident of abuse or neglect. When interviewed on 12/19/13, at 2:50 p.m. the DON stated the administrator and SA should have been notified immediately, because the care plan had not been followed and R48 had suffered a fall. R48's Resident Incident Report dated 12/10/13, at 9:20 a.m. indicated R48 had been left on the toilet, in the bathroom alone. The Incident Investigation indicated staff were re-educated on not leaving R48 unattended on the toilet due to impulsive behavior. The incident was not reported to the administrator until 12/11/13, the next day, and had not been reported to the SA.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 40	F 226		

When interviewed on 12/19/13, at 2:50 p.m. the DON stated it is the facility policy not to leave unsteady or cognitively impaired residents alone in the bathroom. She had re-educated the nurse aide responsible at the time of the fall. The DON stated this should have been reported to the administrator and the SA immediately.

R11's care plan was not followed when R11 fell while left unattended on a commode in her room. The incident was not immediately reported to the administrator or the SA in accordance with the facility's abuse prohibition policy.

R11's Resident Incident Report dated 11/4/13, at 5:00 a.m. indicated she was found on the floor in her room. She had been on the commode and was found ten minutes later on the floor. The report indicated the immediate intervention of, "Educated staff to not leave resident unattended on commode." The report indicated it was not a reportable (abuse or neglect) issue and the administrator was not notified about the incident until the following day, on 11/5/13.

R11's annual MDS dated 10/16/13, indicated she was moderately cognitively intact and required extensive assistance with transfers, ambulation and bed mobility. The MDS also indicated R11 had no falls since the prior assessment on 10/9/13, and she was frequently incontinent of bladder.

R11's care plan dated 10/13/16, indicated she was at moderate risk for falls related to being unaware of hersafety needs, short term memory loss, psychotropic medication use, gait/balance problems, bladder urgency with incontinence, attempts to self-transfer and her need for assist

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 41 of one with transfers and toileting. During interview 12/19/13, at 10:30 a.m. the DON verified R11 had fallen as a result of staff not following her care plan of not leaving her unattended on the commode. The DON stated she did not notify the administrator or the SA immediately because she was not aware it was a reportable incident.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 7 of 41 residents (R18, R6, R12, R20, R13, R24 and R25) who regularly attended resident council meetings from 3/13 through 11/13. Findings include: Review of the resident council meeting minutes from 3/13 through 11/13, identified seven resident R18, R6, R12, R20, R13, R24 and R25 who regularly attended the council meetings had the following concerns:	F 244	F 244 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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 presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 42	F 244		

The 3/29/13 resident council meeting minutes, identified concerns of sufficient staffing within the facility. Documented concerns included, "Wait too long sometimes," and "Need more help."

The 4/26/13 resident council meeting minutes, did not address the previous month's concern regarding sufficient staffing, nor did they reflect whether the facility had responded to the concern, or discussed a plan for addressing this issue.

The 7/26/13 resident council meeting minutes identified a concern of staff failure to respond timely to a resident's call light, "1:15 min [one hour and 15 minutes] before someone helped."

The resident council meeting minutes dated 8/30/13, identified a concern of staff failure to leave call lights within reach of each resident. The minutes did not address the previous month's concern nor did they reflect if the facility had discussed a plan for addressing this issue.

The 9/30/13 resident council meeting minutes, indicated "call lights" under old business but did not address how the facility had responded to the concern or a plan for addressing this issue.

The 11/29/13 resident council meeting minutes indicated a concern of sufficient staffing within the facility. Concerns registered included, "Call lights too long to wait." The Concerns from the Resident Council Meeting sheet filled out by the activity director (AD) and nursing, indicated nursing would evaluate the call light report in morning interdisciplinary team meeting daily, implement hourly customer service rounds, complete a staffing gap analysis to ensure there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 43 was department head support during busier times, and educate staff. Implementation of the planned changes was to begin the week of 12/23/13, twenty four days after the complaint was received. R18, who had attended nine of the nine resident council meetings was interviewed on 12/19/13, at 12:56 p.m. R18 stated, "Sometimes it can take anywhere from 15 minutes to one hour for someone to come [to respond to an activated call light]." R18 could not specify when these waits occurred. The quarterly Minimum Data Set (MDS) dated 10/31/13, indicated R18 was cognitively intact and required extensive assist for toileting and transfers. R6, who had attended four of the nine resident council meetings was interviewed on 12/19/13, at 1:05 p.m. R6 stated she sometimes had to wait 15-20 minutes or more for someone to come after she was assisted onto the commode, "They will tell me to push my button and say they will come back, but that doesn't happen all of the time. Sometimes I have to wait longer." R6 stated that it made her feel uncomfortable to be left on the commode for that long. She reported these waits occurred approximately every other day. The quarterly MDS dated 10/22/13, indicated R6 was cognitively intact, required extensive assistance for toileting and was totally dependent for transfers. During an interview on 12/18/13, at 8:58 a.m. AD indicated that whenever a resident had a concern that was registered during a resident council meeting, a concern sheet was filled out and given to the appropriate department for them to address. AD stated the concerns registered in	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 44 3/13 and 7/13 were not addressed and no action was taken by the facility to resolve the issue. AD stated in 8/13, a written concern sheet was not filled out regarding staff failure to leave call lights within residents' reach, but was verbally forwarded to nursing, who responded by educating the staff and putting the concern on the "24 hour board." AD stated she found residents complain about call lights not being answered "a lot." During an interview with the Director of Nursing (DON) on 12/19/13, at 9:26 a.m. she stated the 24 hour communication board was a tool to communicate any issues to the nurses. When asked about the 8/13 resident concern about call lights and how it was communicated to staff caring for residents, the DON shrugged her shoulders and stated, "I don't check every time they need to tell the staff something," and walked away. On 12/20/13, a complaint and grievance policy was requested but not provided by the facility.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident	F 248	F 248 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 took place outside of the resident room. 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 the channel with the television remote and ensuring that her remote was within reach, assistance/ escort to activity functions, activities which did not involve overly 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 television, listening to the radio, music, talking on the telephone and visiting with family and others. During observation on 12/17/13, at 11:45 a.m. R32 was observed sitting in her room in her wheelchair. The television was on, but there was no volume on, and the resident was playing with a tissue. There was no radio in her room. At the time of this observation there was organ music	F 248	1. Resident # 32 had community life plan reviewed and updated on 12/20/13 with current resident preferences. 2. All Residents activity preferences will be assessed on admission, annually and with significant change in condition and reviewed on a quarterly basis. 3. The ED/DNS and/or her designee will complete two audits per week for one month then weekly for two months. 4. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: January 24, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 46	F 248		

being played in the facility dining room.

During observation on 12/18/13, at 10:20 a.m. R32 was sitting in her wheelchair in her room. The resident was sleeping on and off with the television on in her room. A newspaper was lying on a table behind R32.

During interview on 12/18/13, at 10:25 a.m. R32 stated she liked to listen to the current events and daily news. R32 stated she loved animals, especially dogs. She stated the facility did not have any activities she could be involved in and she only left her room for meals. R32 stated she liked to listen to the radio news shows, but she was not sure why she did not have a radio to listen to in her room.

During observation on 12/18/13, at 1:15 p.m. R32 was observed sitting in her wheelchair in her room. Hockey was on the television with no sound.

During observation on 12/19/13, at 8:50 a.m. R32 was in her room sitting in her wheelchair, sleeping. The television was not on.

During observation on 12/19/13, at 11:20 a.m. R32 was in her room sitting in her wheelchair sleeping. The television was on with no volume and there was no radio in her room.

During observation on 12/19/13, at 3:45 p.m. R32 was in her wheelchair, propelling herself down the hallway with her feet. There was a band playing in the dining room area. She was about five feet down the hallway from her room when nursing assistant (NA)-E walked behind R32 and stated, "Let's go back into your room." NA-E pushed R32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 47 back into her room even though she was in the hallway going towards the music.	F 248		

During interview on 12/19/13, at 3:45 p.m. NA-E stated R32 usually did not come out of her room and when she did she seemed to get more confused. NA-E stated R32 did not come to activities and preferred to stay in her room to watch television and read the paper.

Review of the Life Enrichment Assessment (activity assessment completed on admission) dated 12/24/12, indicated R32 enjoyed exercise, sports, twins and Vikings, and listening to the radio. The assessment revealed R32 liked to have WJON (a local radio station) on all the time per her family. R32 also enjoyed books, shopping, outdoors, flowers and gardening, talking and conversing, parties and social events, reminiscence, visitors, pets, and sorting things. The preferred activity settings were identified as follows: R32's resident room, the facility day room and the facility activity room. The activity assessment summary noted, "Bath weekly, retired catholic and no longer attends or practices, likes talk radio and having T.V. [television] on (WJON), newspaper daily and sorts things daily. Phone within reach."

R32's facility Recreation/ Wellness Assessment dated 12/12/13, indicated all past preferences and the only current preferences were communion, music and reminiscing. A summary on the form indicated, "Happy hour red wine, would like music."

The facility assessment titled Preferences for Customary Routine and Activities dated 12/12/13, indicated it was "very important" for R32 to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 48 books and newspapers to read, be around animals, keep up with the news, get fresh air, and to participate in religious services or practices. The resident indicated it was "somewhat important" to listen to music she liked, do things with groups of people, and do her favorite activities. Review of R32's record of activities attended, Daily Activity Involvement Record for 12/13, indicated she had "refused" all activities offered. Facility staff had documented, "self-directed leisure" daily, which included looking out her window, reading, and television in her resident room. Review of the activity progress notes identified R32 had only three activity visits in December to date (12/19/13), and six activity visits in November 2013. The activity visits were all noted in R32's room, talking about all the snow and her magazines. On 11/14/13, activity visits noted, "Visited with [R32] about music and she smiled and stated to staff 'I'd like that.' Staff talked with [R32] about favorite songs and she stated 'organ.' On 10/22/13, activity visits noted "Visited with [R32] about listening to organ music, she smiled and stated 'I really like organ music." During interview on 12/20/13, at 11:00 a.m. licensed practical nurse (LPN)-A stated R32 usually refused activities but did like music and sometimes bingo. LPN-A stated she was not sure of R32's specific interests, nor whether she liked to come out of her room or not. She stated activities usually offered R32 choices and preferences.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 socials or pizza parties, but it was a "hit or miss" if the resident came to the activity or not. She stated at times R32 would come to an activity and then leave half way through. She stated the facility did daily news before lunch, and R32 was "usually" invited to come. A-A stated she began working at the facility in 5/13 and was still in the process of getting to know resident likes and dislikes. Although R32 had specific likes and dislikes, and 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 provided.	F 248		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was followed for 3 of 5 residents (R32, R48 and R11) who were reviewed for falls and for 1 of 2 residents (R47) reviewed with pressure ulcers. Findings include: R32's care planned interventions for fall prevention were not followed by staff.	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 50 R32's quarterly Minimum Data Set (MDS) dated 9/26/13, identified the resident had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs) except eating, and was frequently incontinent of bladder. R32's care plan dated 10/29/13, instructed, "[R32] is at risk for falls related to history of Parkinson's with behavioral disturbance, poor safety decisions, and need for assist with ADLs and toileting. Had fall on 5/1/13 with right hip fracture and pelvic ring fracture... pelvic fracture 9/20/13 due to fall 9/17/13." The facility interventions were "Anti-rollback mechanism to wheelchair to prevent any falls... has asked not to be offered toileting more than upon rise, HS (hour sleep), before meals, and with staff assisted repositioning to prevent falls... family is opposed to TABS alarm placement for fall notification... room close to nursing station to facilitate more frequent monitoring for self-transfers... non-slip product on top of wheelchair cushion to prevent sliding out of wheelchair, remove wheelchair pedals when not being propelled by staff... would like phone placed on bed after bed is made in morning to ease access... ensure remote is within her reach when in her room..." The current nursing assistant (NA) worksheet dated 12/17/13, instructed staff to "assist resident to lie down when displaying poor posture and between meals... fall prevention: If walking independently provide gentle cues. Do not force to sit in wheelchair. If in room alone assure over bed table over legs, use side cushion when leaning. Reposition every 2-3 [two to three] hours." During observation on 12/17/13, at 11:22 a.m.	F 282	1. Resident #32 had care plan reviewed and interventions updated for falls. Resident #32 has been on frequent monitoring to ensure that interventions have been in place. 2. Resident #48 had care plan reviewed and interventions updated for falls. Resident #48 has been on frequent monitoring to ensure that interventions have been in place. had care plan reviewed 3. Resident #11 had care plan reviewed and interventions updated for falls. 4. Resident #47will have comprehensive skin assessment completed by 1/24/14 and care plan will be updated accordingly. 5. All residents with falls in past 6 months were reassessed with abatement plan and care plan updated accordingly. 6. Residents with current pressure ulcers will be reassessed and care plan updated accordingly by 1/24/14. 7. Staff educated during abatement plan on how to identify residents care planned interventions on the care sheets, as well as how new fall interventions will be communicated.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 51 R32 was in her room in her wheelchair. The call light was on the floor behind her, with the bedside table next to her and the phone on the nightstand. R32 was leaning over trying to pick up Kleenex off the floor and the wheelchair rolled back slightly each time she leaned forward. During interview on 12/17/13, at 11:34 a.m. NA-B stated R32 used her call light "sometimes." She stated if staff placed her bedside table in front of her with all of her supplies, she generally did not self-propel around the room in her wheelchair. NA-B verified R32's room was not set up according to the plan of care with the bedside table in front of her to prevent falls. During observation on 12/18/13, at 10:20 a.m. R32 was sitting in her wheelchair in her room. The bedside table was located against the wall, with the telephone on it and the call light was wrapped around the grab bar on her bed. Both were about four to five feet away from R32 and were not within her reach. R32 was seated on a wheelchair cushion; however, no anti-slip pad was observed on the cushion. During interview on 12/18/13, at 10:36 a.m. director of nursing (DON) verified R32 should have had her bedside table placed in front of her with the telephone, newspaper, remote control, and call light within reach. During observation on 12/18/13, at 1:15 p.m. R32 was observed sitting in her wheelchair in her room. The call light was pinned to the bed behind her, about two feet behind her. The newspaper was on the bed and the phone was under the newspaper. The remote control was on the bed and there was no anti-slip mat on R32's	F 282	8. The DNS or designee will complete five audits per week for one month. 9. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Date of Completion: January 24, 2014	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 52	F 282		

wheelchair cushion as directed by the care plan.

During interview on 12/18/13, at 1:20 p.m. the above observation of R32 was verified the MDS nurse and confirmed R32 call light, remote control, newspaper, and phone should be with in R32 reach. She stated the anti-slip mat was under R32's wheelchair cushion but was not visible. She was unaware the care plan directed staff that R32 was to have an anti-slip mat on top of the wheelchair cushion to prevent her from sliding out of her wheelchair.

During observation on 12/19/13, at 8:50 a.m. R32 was in her room sitting in her wheelchair, sleeping. The bedside table was behind her wheelchair with the remote control on it. The call light was wrapped around the grab bar on the bed which out of R32 reach.

During observation on 12/19/13, at 11:20 a.m. R32 was in her room sitting in her wheelchair, sleeping. The bedside table was behind her wheelchair with the remote control on it. The call light was pinned to the bed, approximately three to four feet away from the resident.

Although R32 had multiple falls and interventions were identified on the care plan to help prevent these falls, the care plan was not implemented to prevent further falls.

R48's care planned interventions for fall prevention had not been followed by staff.

R48's admission MDS dated 10/18/13, included diagnoses of hip fracture, hypertension (elevated blood pressure), and dementia. The MDS indicated R48 had severe cognitive impairment,

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 53 required extensive assistance for all ADLs, and had fallen prior to admission. The fall Care Area Assessment (CAA) dated 10/16/13, indicated R48 was at risk for falls related to poor balance and cognitive deficit, care planning would occur due to these risks. R48's care plan dated, 10/24/13, included, "[R48] is at risk for falls r/t [related to] history of, cognitive loss with impaired decision making, incont [incontinent], new to environment, daily analgesia use, and osteoporosis." The care plan directed staff to ensure her call light was in reach, her bed in low position, and needs anticipated. The care plan also directed staff to attempt to determine the cause of any falls. An undated NA Care Plan for R48, directed staff to leave walker in place, perform 15 minute checks, and keep her bed at an appropriate transfer height. R48's Resident Incident Report dated 11/2/13, at 12:00 a.m. indicated R48 had fallen while trying to get out of bed, her bed had been in the lowest position, not at transfer height as directed by the care plan. R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. indicated R48 had fallen trying to get out of bed. The Incident Investigation indicated her walker had not been in reach as directed by the care plan. Staff were re-educated on leaving walker within reach. R48's Resident Incident Report dated 12/10/13, at 9:20 a.m. indicated R48 had been left in the bathroom on the toilet alone. The Incident Investigation indicated staff were re-educated on	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 54 not leaving R48 unattended on the toilet due to impulsive behavior. When interviewed on 12/19/13, at 2:50 p.m. the DON verified the care plan had not been being followed when R48 had fallen on 11/2/13 and 11/13/13. The DON further stated it was the facility policy not to leave cognitively impaired residents alone in the bathroom. When interviewed on 12/19/13, at 4:47 p.m. licensed practical nurse (LPN)-A stated R48 tended to forget to activate her call light on and tried to transfer herself once or twice a day, attempting to go to the bathroom. When interviewed on 12/19/13, at 4:49 p.m. NA-L stated R48 attempted to transfer herself once or twice a week. R48 was not to be left alone in the bathroom. NA-L did not know what position R48's bed was supposed to be in, or where her walker was supposed to be located. During observation and interview on 12/19/13, at 5:00 p.m. R48 stated the "girls," help her to the bathroom. She was otherwise not oriented to time or place. R48 was in bed, with the bed in a low position and her walker across the room, by the entrance door, not by her bed. When interviewed on 12/19/13, at 5:05 p.m. NA-K stated R48 was not to be left in the bathroom alone, her bed was supposed to be "a little down." NA-K added that they determined that height by having R48 sit on the edge of the bed, ensuring her feet touched the floor. After consulting R48's Nursing Assistant Care Plan, NA-K stated R48's walker was to be next to her bed, and acknowledged the walker was currently across	F 282		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 55 the room.	F 282		

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, low bed, floor mat next to her bed, nonslip cushion in her wheelchair, anti-rollback brakes on 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 indicated R11 had no falls since the prior 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 56 diuretic and was frequently incontinent of urine. The CAA also indicated R11 was alert and disorientated with a recent history of frequent falls in addition to intentional position changes. The CAA also indicated interventions including monitoring health status for changes, regular toileting with reproach ten minutes later if she declined the offer, pain management, low bed with pressure sensor, alarm in wheelchair, and room next to nurse's station. The CAA did not identify looking at extrinsic factors or re-evaluating her toileting plan related to falls. R11's Resident incident reports revealed the following falls related to staff not following plan of care and resident toileting: Fall on 11/4/13, at 5:00 a.m. resident found on floor in her room, had been on commode and was found ten minutes later on the floor. The incident report indicated the immediate intervention was to re-educate staff not to leave resident unattended on the commode. Fall on 9/30/13, at 4:45 a.m. resident found on floor mat next to bed. The fall investigation indicated resident had last been toileted at 2:00 a.m. and during interview with nursing assistant she checked her pad at 4:00 a.m. but did not go back and check to see if she needed to use the toilet soon after. Educated nursing assistant to plan of care and care sheets that state resident should be checked and offered toileting every two hours at night, if she stated she did not need to void, they were to go back in approximately ten minutes later and ask again. Registered nurse on night shift also educated. Fall on 8/22/13, at 2:35 a.m. resident found on fall mat sitting next to bed. The falls investigation indicated staff reported that they had not toileted resident on the night shift, and they typically checked the resident every two hours and ask if	F 282		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 57 she needed to use the toilet but they did not necessarily get R11 up if she said no to toileting or reoffer toileting. R11 was care planned that staff would go in and offer to toilet her every two hours, if she was sleeping staff were still to wake her up and ask her if she needed to toilet and check her brief. If she was dry staff were to return in ten minutes and if she was still awake, staff were to ask her again. During interview on 12/19/13, at 10:30a.m. DON verified that the falls all occurred due to staff not following R11's care plan when they should have. The facility failed to offer or implement timely repositioning for R47 as directed by the plan of care. R47's care plan, last reviewed on 10/16/13, identified the pressure ulcers, and included various interventions that directed, "[R47 was to] be repositioned or off-loaded per TTT [Tissue Tolerance Test- a test used to measure tissue profusion] every hour recommended d/t [due to] presence of pressure ulcers, however, [R47] compromised at 2 hours. Respect [R47's] right to decline this while explaining risk/benefits." The Group-A NA worksheet, dated 12/18/13, directed staff to turn and reposition [R47] every two hours and PRN (as needed). During observation on 12/18/13, from 6:50 a.m. to 9:42 a.m., (2 hours and 52 minutes), R47 was lying on his back in his bed with the head of the bed slightly elevated. During the constant observation R47 was not offered repositioning by staff. At 7:59 a.m., licensed practical nurse (LPN)-B entered the room and administered medications to R47 via a feeding tube. At 8:17	F 282		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 58	F 282		

a.m., LPN-B completed R47's medication administration, and exited the room. LPN-B did not offer or reposition R47 while in the resident room during the medication administration.

At 9:41 a.m. NA-D entered R47's room, noted an odor and requested assistance. At 9:42 a.m., NA-C entered the room and assisted NA-D with continence care and repositioning of R47.

During an interview on 12/18/13, at 9:43 a.m., NA-D could not recall when R47 was last repositioned, but verified it had been longer than two hours. In another interview at 10:33 a.m., NA-D verified R47 needed to be repositioned every two hours per the plan of care. NA-D stated although R47 refused repositioning at times, the resident was still to be offered according to the plan of care.

During interview on 12/18/13, at 10:31 a.m. LPN-C stated R47 preferred to lay on his back and the resident currently had pressure ulcers on his upper back. LPN-C reported R47 was on a two hour repositioning schedule per the plan of care. LPN-C stated R47 was at high risk to develop pressure ulcers because of "dependence, immobility," and other risk factors. LPN-C also acknowledged R47 was not repositioned after the medication administration around 8:00 a.m.

During an interview on 12/18/13, at 10:36 a.m., the DON stated it was "essential" that residents were repositioned timely, and she "expected the care plan be followed for residents with pressure ulcers." DON agreed repositioning needed to be offered for R47 even if the resident had refused in the past.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess and consistenly monitor 1 of 1 residents (R48) that had an elevated blood pressures and change in neurological symptoms after a fall. In addition, the facility failed to assess and monitor 1 of 4 residents (R50) reviewed for nutrition, for symptoms of congestive heart failure. Findings include: R48 had elevated blood pressures, multiple head injuries, and abnormal neurological assessments. The facility failed to consistently monitor these symptoms, or notify the physician. R48's admission Minimum Data Set (MDS) dated 10/18/13, included diagnoses of hip fracture, hypertension (elevated blood pressure), and dementia. The MDS indicated R48 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADLs), and had fallen prior to admission. R48's Fall Risk Assessment dated 10/7/13, listed risk factors for falls, including use of	F 309	F 309 — The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 60 antihypertensive medication, a blood pressure was included of 166/67; however, did not include an orthostatic blood pressure (blood pressure taken while lying, sitting, then standing used to determine if there was a drop in blood pressure with position changes; a potential side effect of antihypertensive medication, which can lead to feeling dizzy or lightheaded and could potentially cause a fall). R48's care plan dated 10/24/13, included hypertension (high blood pressure) as a focus, and directed staff to, "Observe/document/report to medical practitioner PRN [as needed] and s/sx [signs or symptoms] of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea)." R48's physician orders dated 12/2/13, included three medications to control hypertension: Accupril 20 mg (milligrams) daily; Cozaar 60 mg daily, and Toprol XL 100 mg daily. R48's Resident Incident Report dated 10/27/13, indicated she had fallen in her room at 11:25 a.m. Blood pressures at the time of the fall were documented as: lying 203/82 mm (millimeters) hg (mercury) and sitting 167/76 (normal blood pressure 120/80). The next documented blood pressure (183/76) was located in R48's electronic record under Progress Notes dated 10/28/13, at 5:07 a.m. R48's blood pressure remained elevated more than 17 hours after the fall. There was no evidence in R48's medical record to indicate her physician had been notified of the elevated blood pressures or of the drop in blood pressure between lying and sitting. In addition,	F 309	1. 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 will be completed if change noted per change in condition guidelines. 2. Resident #48 had blood pressure monitoring every 2 hours from 12/20/13 through 12/26/13 with no significant elevated blood pressures noted. 3. Progress notes will be reviewed by DNS or designee 5 times per week for 4 weeks. 4. Nursing staff education will be completed by January 24, 2014 on policy and	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 61 no further orthostatic blood pressures had been documented. R48's Resident Incident Report dated 11/2/13, at 12:00 a.m. indicated a second fall had occurred, with a blood pressure of 215/81 noted at the time of the fall. R48 hit her head during the fall and a Neurological Assessment Flow Sheet was initiated, which included frequent blood pressure checks during the 24 hours following the fall. In addition, the Neurological Assessment Flow Sheet indicated R48 had complained of head pain on 11/2/13, at 12:05 a.m., and again at 3:50 a.m. The final blood pressure check on 11/3/13, at 12:30 a.m. was 176/70. The next documented blood pressure (187/78) was located under Vital Signs in the electronic record dated 11/5/13, at 10:29 a.m. R48's blood pressure had remained elevated three days after the fall. There was no evidence in R48's medical record that an orthostatic blood pressure had been taken, or that the blood pressures and head pain had been monitored and reported to the physician. R48's Resident Incident Report dated 11/8/13, at 12:30 a.m. indicated R48 had fallen a third time. During this fall, R48 hit her head and sustained a three centimeter (cm) by four cm hematoma (large collection of blood under the skin) to the back of her head. R48's blood pressure at that time was 181/84 sitting and 199/103 lying. A Neurological Assessment Flow Sheet was initiated, dated 11/8/13, and blood pressure checks were completed every four hours for 24 hours. At 4:00 a.m. her blood pressure remained elevated at 199/75. The Neurological Assessment Flow Sheet indicated R48's pupils had been equal round and reacted to light until 8:00 a.m. at which time they were documented as	F 309	procedure of change in condition notification 5. . The DNS and/or her designee will conduct audits weekly on any residents with a change in condition and assure these conditions are identified on the resident care plan. 5. All incident reports will be reviewed by DNS, ED and/or designee post incident for discrepancies in vital signs 6. 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 Completion date: January 24, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. A progress note dated 11/8/13, at 11:10 a.m. noted R48 complained of a headache and had vomited 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, "Pupils 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 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	F 309		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 63	F 309		

needed]." The blood pressures recorded were between 113/61 to 183/96. There was no evidence the NP or physician had been notified of R48's elevated blood pressures at the time of her falls on 10/27/13, 11/2/13, 11/8/13, or 11/13/13.

R48's NP Nursing Home Rounds report dated 11/22/13, included a physical exam. The NP noted, "I do not have weights or vital signs to review, but I am not made aware of any problems." The NP also noted under Assessment, "Hypertension, but I am not aware of any problems."

R48's Resident Incident Report dated 11/24/13, at 10:25 p.m. indicated R48 had fallen a fifth time. The report noted R48 "bumped" her head during the fall. R48's blood pressure at that time was recorded as 210/83 sitting. A Neurological Assessment Flow Sheet was initiated, with blood pressures recorded between 113/61 and 200/83 over the 24 hours following her fall. R48's pupils were recorded as either non-reactive or sluggish. A Centracare Clinic Fax was sent to the physician describing the fall, but noted only a blood pressure reading of 161/66. There was no evidence the physician had been notified of the 210/83 and 200/83 readings, or the non-reactive or sluggish pupils. There was no monitoring of orthostatic blood pressures during this time, even though R48 had a history of an orthostatic drop in blood pressure.

R48's Nursing Home Rounds by the physician dated 12/11/13, included, "She had a minor fall on November 8, 2013, without sequelae [without complication]; also on October 28, 2013. Under physical exam the note included, "For technical reasons, her blood pressures and weights are not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 64	F 309		

available." There was no evidence the physician was informed of the head injury sustained on 11/8/13, 11/13/13 and 11/24/13 with the symptoms of vomiting, head pain, and abnormal neurological assessments. Also, there was no indication the physician was informed of the elevated blood pressures following each of the falls which occurred on 10/27, 11/2, 11/8/13, 11/13, and 11/24/13.

When interviewed on 12/19/13, at 2:50 p.m. the director of nursing (DON) stated R48 should have had continued monitoring of symptoms of hypertension, orthostatic blood pressures, and declining neurological symptoms. In addition, the physician should have been made aware of each of these. The DON verified this had not occurred for R48.

Even though R48 had sustained multiple falls at which time her blood pressure had been elevated, she had a dramatic drop in blood pressure between lying and sitting, and sustained repeated head injuries with declining neurological symptoms (change in pupil reaction to light), the facility failed to notify the physician, or continue monitoring symptoms.

An undated facility policy for Change in Condition, When to Report to the MD (medical doctor) /NP/PA (physician's assistant) directed staff to report any systolic (heart contraction) blood pressures over 210, diastolic (heart relaxation) over 115 immediately, and diastolic routinely over 90 the next day. The form also indicated the need to contact the physician if the resident sustained a contusion associated with a recent fall with no other complications, and to send the resident to the emergency room immediately

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 65 following a fall with a head injury. R50 had weight gain, edema and dyspnea which the facility failed to monitor for congestive heart failure. 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 hospital and 108 lbs on 11/10/13. R50's hospital discharge orders dated 11/11/13, indicated she received atenolol 50 milligrams (mg) and diovan for hypertension. The discharge orders instructed to "call your physician if you gain 3 [three] pounds or more over night, or gain 5 [five] pounds in a week..." The orders also directed a referral on 11/20/13, for a follow-up appointment with her physician. R50's current care plan dated 11/27/13, identified a problem of hypertension and received anti-hypertensive medications (blood pressure medications). The plan instructed staff to notify her medical practitioner of any signs or symptoms of malignant hypertension including the following: headache, visual problems, confusion, and difficulty breathing. The care plan did not indicate R50 had a history of congestive heart failure and to monitor for fluid retention and weight gain.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 66 Review of the facilities Weights and Vitals Summary revealed the following weights: 11/12/13 118 lbs (up ten lbs from hospital discharge weight on 11/11/13, one day prior) 11/16/13 119 lbs 11/19/13 119 lbs R50's had a physician visit on 11/20/13, nine days post her hospital discharge. The office visit noted indicated R50's weight was 117 lbs. The physician commented R50 was up ten lbs and some dyspnea (difficulty breathing) and lower extremity edema. The physician ordered hydrochlorothiazide 25 mg daily (used to treat high blood pressure and edema). When interviewed on 12/19/13, at 2:50 p.m. the assistant director of nursing (ADON) stated R50 should have had continued ongoing monitoring for symptoms for congestive heart failure and been placed on an edema measurement flow sheet to monitor her CHF, which was not completed. Even though R50 had symptoms of dyspnea and lower extremity edema with a ten lbs weight gain, the facility failed to consistently monitor R50 for symptoms of CHF.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 67 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer or provide timely repositioning for 1 of 2 residents (R47) reviewed with current pressure ulcers. Findings include: R47's diagnoses, as listed on the care plan dated 7/30/13, included paralysis and stage two pressure ulcers. The admission Minimum Data Set (MDS), dated 7/17/13, identified R47 had no cognitive impairment, was dependent upon, and required total assistance of two staff for activities of daily living (ADLs), including repositioning. The care area assessment (CAA) for pressure ulcers, dated 7/23/13, indicated R47 had a severe risk to develop pressures ulcers related to quadriplegia, total bowel incontinence and [R47's] refusal of repositioning. The CAA also indicated R47 was admitted with and had two current pressure ulcers on the right scapula. During continuous observation on 12/18/13, from 6:50 a.m. to 9:42 a.m., (2 hours and 52 minutes), R47 was lying on his back, atop his bed, with the head of bed was slightly elevated. During this time, R47 was not repositioned. At 7:59 a.m., licensed practical nurse (LPN)-B entered the room and administered medications to R47 via a feeding tube. At 8:17 a.m., LPN-B completed R47's medication administration, and exited the room. LPN-B did not offer or reposition R47 while in the resident room during the medication administration. At 9:41 a.m., nursing assistant	F 314	F314 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Resident #47will have comprehensive skin assessment completed by 1/24/14 and care plan will be updated accordingly. 2. Residents with current pressure ulcers will be reassessed and care plan updated accordingly by 1/24/14. 3. Staff educated during abatement plan on how to identify residents care planned interventions on the care sheets, as well as how new interventions will be communicated.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	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. 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 it had been 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 repositioning, even if he refused. R47's care plan, last reviewed on 10/16/13, identified the pressure ulcers, and included various interventions that directed, "[R47 was to] be repositioned or off-loaded per TTT [Tissue Tolerance Test- a test used to measure tissue profusion] every hour recommended d/t [due to] presence of pressure ulcers, however, [R47] compromised at 2 hours. Respect [R47's] right to decline this while explaining risk/benefits." The Group-A NA worksheet, dated 12/18/13, directed staff to 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, intact surrounding skin, and minimal	F 314	4. The DNS or designee will 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 Completion date: January 24, 2014	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 69 serosanguinous drainage from the lower wound. The superior (upper) wound measured one (1) centimeter (cm) x 1 cm x 0 cm; and the inferior (lower) wound measured 0.6 cm x 0.5 cm x 0 cm. A review of the weekly wound notes from 10/29/2013 to 12/17/2013 further indicated evidence the pressure ulcers were healing. During interview on 12/17/13, at 10:31 a.m. LPN-C said that R47 preferred to lay on his back, and that R47 was often non-compliant with treatment. LPN-C added that R47's preferences were in the care plan. LPN-C confirmed that R47 had pressure ulcers on his upper back, and was on a two-hour repositioning schedule per his plan of care. LPN-C said R47 was at high risk to develop pressure ulcers because of "dependence, immobility," and other risk factors. LPN-C also acknowledged that R47 was not repositioned after the medication administration around 8:00 a.m. During an interview on 12/18/13, at 10:36 a.m., the director of nursing (DON) stated the NAs needed to reposition residents with pressure ulcers according to the plan of care. The DON said it was "essential" residents be repositioned timely, and she "expected the care plan be followed for residents with pressure ulcers." A facility policy regarding care of residents with pressure ulcers was requested; none was provided.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F323 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 70 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident falls were comprehensively assessed and interventions implemented to prevent falls for 4 of 5 residents (R32, R48, R11 and R66) reviewed with falls. The facility failed to investigate and comprehensively assess resident falls to determine if new interventions could be implemented, nor did the facility assure the interventions were currently in place or were consistently implemented in preventing falls which resulted in multiple fractures for R32 and a significant head injury for R48. The facility's failure resulted in an immediate jeopardy, with serous harm and injury for R32 and R48. In addition to the residents in immediate jeopardy, the facility failed to comprehensively assess falls resulting in potential for harm that that was not immediate jeopardy for 2 out of 5 residents (R11 and R66) in the sample with falls. The immediate jeopardy was identified on 12/19/13 when the facility failed to comprehensively assess and implement interventions to prevent ongoing falls. The administrator, director of nursing, corporate nurse, and executive director were notified of the immediate jeopardy (IJ) for R32 and R48 on 12/19/13, at 6:00 p.m. The immediacy was	F 323	1. All residents who have had a fall within the past 6 months will be reassessed for fall risks upon by noon 12/20/13, to assure the assessment is comprehensive and to ensure that residents have appropriate interventions are being utilized. 2. All incidents are reviewed by DNS and/or ED or designee upon notification for appropriate interventions, to assure that care planned approaches were being followed, and to review for possible vulnerable adult reporting. 3. All incidents are reviewed by facility Inter Disciplinary Team (IDT) for appropriateness of interventions and any necessary modifications to residents plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 71 removed on 12/20/13, at 2:00 p.m. but noncompliance remained at an isolated scope and severity level, of actual harm that was not immediate jeopardy. Findings include: R32 had 23 falls in the past 10 months, with significant fractures. The facility had not compressively assessed, or implemented consistent interventions to decrease the risk of falls for R32, which resulted in an immediately jeopardy. R32 quarterly Minimum Data Set (MDS) dated 9/26/13 identified R32 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADL's) except eating, and was frequently incontinent of bladder. R32 was currently in an assessment period and the facility provided the Care Area Assessment (CAA) related to falls dated 12/12/13 which indicated "Resident at high risk for falls due to history of multiple falls, incontinence, impaired decision making, inability to identify safety concerns, orthostatic blood pressure changes, and Parkinson's disease with shuffling gait and poor trunk control. Resident does have 'good days' and 'bad days.' At times resident will lean significantly in her wheelchair due to poor trunk control and she does have a positioning cushion in her wheelchair. Resident does have anti rollback device on wheelchair. Alarms and safety concerns have been discussed with family at length and negotiated risk is in place. Family wishes to have no limitations on residents mobility and would like her to be allowed to freely move in her wheelchair and do not want resident to feel	F 323	4. All facility staff will be reeducated at employee meetings held 12/19/13 at 2000 and 2200, 12/20/13 at 0600, 0700, 0830, 1100, and 1400. Employees unable to attend were educated via telephone prior to next scheduled shift and will receive packet of education materials prior to beginning next scheduled shift. No employee will be allowed to work unless education has been provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 72 restricted in any way. Family does understand consequences of resident falls." R32's care plan dated 10/29/13 indicated resident "is at risk for falls related to history of Parkinson's with behavioral disturbance, poor safety decisions, and need for assist with ADL's and toileting. Had fall on 5/1/13 with right hip fracture and pelvic ring fracture...pelvic fracture 9/20/13 due to fall 9/17/13." The facility interventions were "Anti-rollback mechanism to wheelchair to prevent any falls... has asked not to offered toileting more than upon rise, HS (hour sleep), before meals, and with staff assisted repositioning to prevent falls... family is opposed to TABS alarm placement for fall notification... room close to nursing station to facilitate more frequent monitoring for self transfers... non-slip product on top of wheelchair cushion to prevent sliding out of wheelchair, remove wheelchair pedals when not being propelled by staff... would like phone placed on bed after bed is made in morning to ease access... ensure remote is within her reach when in her room..." The current nursing assistant (NA) worksheet dated 12/17/13 which the facility identified the NA use to provide care to R32 instructed staff to "assist resident to lie down when displaying poor posture and between meals... fall prevention: If walking independently provide gentle cues. Do not force to sit in wheelchair. If in room alone assure over bed table over legs, use side cushion when leaning. Reposition every 2-3 hours." The facility provided a Negotiated Risk Agreement signed by R32's family on 10/3/13. The agreement indicated the following, "The purpose of this negotiated risk agreement is to	F 323	5. 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. 6. SPHCC fall protocols, have been reviewed and no changes have been made 7. 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, non-skin products, anti tip bars on w/c • protective devices such as fall mat, low bed • Additional monitoring for toileting needs, infections, etc...	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 73 describe residents choice with respect to the following issue: Walking independently with the use of a wheel walker, or pushing her wheelchair which parties acknowledge is a valid exercise of his/ her resident rights. The negotiated risk agreement will identify the residents choice, outline the risks and possible consequences of residents choice, identify alternatives offered to decrease risk, and then describe the final agreement between the parties. Risks: Consequences include: falling, falling may result in injury up to and including death. Final agreement between the parties evidencing resident final choice following a discussion of the risks and the plan of action to decrease risk is as follows: staff will give verbal cues on safety when witnessing a potential risk and may shadow [R32] to ensure safety while not encroaching on [R32] comfort or right to ambulate." During observation on 12/17/13 at 11:22 a.m. R32 was sitting in her wheelchair in her room. The call light was on the floor behind the resident, the bedside table was sitting next to the resident, and the phone was on the nightstand. R32 was leaning over trying to pick up Kleenex that was on the floor. The wheelchair rolled back slightly each time the resident leaned forward in an attempt to pick up the Kleenex on the floor. The surveyor requested assistance from nursing assistant (NA)-B. During interview on 12/17/13 at 11:34 a.m. NA-B stated R32 will use her call light "sometimes". She stated if staff places her bedside table in front of her with all of the supply's, she will generally not move around the room in her wheelchair. NA-B verified R32's room was not set up according to the care plan, with the	F 323	8. Staff education regarding implementation of hourly customer service rounds will be completed by January 24, 2014 9. Root cause analysis completed with all falls and 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	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 74	F 323		

F 323

bedside table in front of the resident to prevent falls.

During observation on 12/18/13 at 10:20 a.m. R32 was sitting in her wheelchair in her room. The bedside table was sitting against the wall with the telephone on it and the call light was wrapped around the grab bar on her bed, both were about 4-5 feet away from R32, and she was unable to reach these items. R32 was sitting on a wheelchair cushion, however, there were no anti slip pad observed on the wheel chair cushion.

During interview on 12/18/13 at 10:25 a.m. R32 stated she needed to turn the call light on when she has to use the bathroom but sometimes she is unable to get to her call light so she just goes to the bathroom by herself.

During interview on 12/18/13 at 10:36 a.m. director of nursing (DON) verified R32 should have her bedside table placed in front of her with the telephone, newspaper, remote control, and call light within reach. The DON stated R32 does not always use her call light when she needs to go to the bathroom. As the DON was leaving R32's room, the resident stated, "Can you please help me to the bathroom before you leave?"

During observation on 12/18/13 at 1:15 p.m. R32 was observed sitting in her wheelchair in her room. The call light was pinned to the bed behind her approximately two feet, the newspaper was on the bed and the phone was under the newspaper. The remote control was on the bed and there was hockey on the television. There was no anti slip mat observed on R32's wheelchair cushion as instructed in the care plan.

F 323

Plan of Correction for R32

Fall Risk Assessment completed 12-19-13. Risk factors identified, care plan and care sheets reviewed and updated with current interventions. Occupational Therapy Evaluation for wheelchair positioning, environmental adaptations and safety that may reduce fall risk completed on 12-19-13 and will continue to be ongoing.
Will try a larger table for R32 to keep papers and other belongings on that is stationary. Trial will be ongoing to determine appropriateness.

Fall prevention Interventions:

- Necklace pendant given to R32 at 5:00pm on 12-19-13. Resident and daughter were educated on use of pendant. Flow sheet with hourly documentation on pendant use and tolerance initiated.
- Every fifteen minute checks initiated 7:00pm on 12-19-13. Flow sheet started to monitor checks.

Monitoring will be ongoing to determine if interventions are appropriate and implemented consistently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 75 During interview on 12/18/13 at 1:20 p.m. MDS nurse verified R32 was suppose to have the call light available as well as the remote control, newspaper, and phone; and they were currently all out of reach. MDS nurse stated the anti slip mat was under the wheelchair cushion and it was not visible. MDS nurse was not aware the plan of care indicated R32 was to have a anti slip mat on top of the wheelchair cushion to prevent the resident from slipping out of the wheel chair. During observation on 12/19/13 at 8:50 a.m. R32 was in her room sitting in her wheelchair sleeping. The bedside table was behind her wheelchair with the remote control on it. The call light was wrapped around the grab bar on the bed which was about four feet behind the resident. During observation on 12/19/13 at 11:20 a.m. R32 was in her room sitting in her wheelchair sleeping. The bedside table was behind her wheelchair with the remote control on it. The call light was pinned to the bed, approximately 3-4 feet away from the resident. Record review identified R32 had 23 falls from February 2013- December 2013. The facility provided for each fall a Resident Incident Report, Progress Notes, and a word document untitled which the facility stated was a "summary" of each fall. The falls were reviewed as follows: 2/5/13- 11:30 a.m. "Resident was found on the floor of her room on her hands and knees near the bathroom door. Resident stated that she was trying to fill her pop bottle with water in the bathroom. Resident was not incontinent at time of fall and her pad was dry. Resident had been assisted to the bathroom between 10:00-10:30	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 will refuse to have them on at times. • Do no leave unattended on the toilet. • Offer toileting between hours of 2:00pm and 4:00pmas this was a time identified by IDT team as a pattern of fall time. • Cushion with anchors placed in wheelchair. • Keep items off the floor. • Encouraging R32 to come out of her room more often and to engage resident with others to help reduce falls. • Pharmacy will review medications on 12/20/13 Social Service and Community Life will reassess for programs to trial by 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 76 a.m. which is appropriate per her care plan. Again, family does not want to add any fall interventions which would restrict resident in any way from getting up on her own." During interview on 12/17/13 at 11:00 a.m. DON stated no new interventions were put into place after the fall on 2/5/13 because R32 had refused her Parkinson's medications and the facility felt the fall was related to not taking her medications. 2/8/13- 12:00 p.m. "Resident was found on floor of her room sitting against the closet. Resident stated she was trying to walk over to her roommate to talk with her about something. Residents roommate not in the room at the time of fall... Resident was not incontinent at time of fall and her pad was dry... Again, family does not want to add any fall interventions which would restrict resident in any way from getting up on her own." During interview on 12/17/13 at 11:00 a.m. DON stated no new interventions were put into place after the fall on 2/8/13 because R32 had refused her Parkinson's medications and the facility felt the fall was related to not taking her medications. 2/15/13- 4:00 p.m. "Resident was found in her room sitting next to her bed. Wheelchair was also near the resident and it appeared that the resident had been in her wheelchair and was attempting to self transfer out of wheelchair when she fell... Resident was not incontinent at time of fall and denied need to use toilet... Family again deny use of any devices that would restrict [R32] from getting up on her own." 2/15/13- 10:00 p.m. "Resident was found on floor	F 323	• Sorting and organizing items • Increased 1:1 time from 3 to 5 times per week- Mon, Wed, Friday between 2-4, Tuesday and Thursday at various times as a trial. Will attempt 1:1 outside of the room. • Family visits almost daily- continue to ask them for any ideas on interests and activity preferences. • Bookkeeping items- calculator, pens • Will look for smaller group activities and encourage resident to attend. **Plan of Correction R48** New Fall Risk Assessment completed 12-19-13. Risk factors indentified, care plan and care sheets reviewed and updated with new interventions. Occupational Therapy order to Evaluate for Strengthening, Balance, safety with walker and environment for any adaptations and modifications that may reduce fall risk on 12/20/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 77 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 that resident had been in her wheelchair 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 future." Included in the Incident investigation was	F 323	Interventions: • Necklace pendant given to R48 at 7:30pm on 12-19-13. Flow sheet with hourly documentation on pendant use and tolerance initiated. Resident was educated on how to appropriately use call pendant. • Monitoring will be ongoing to determine if interventions are appropriate and implemented consistently. • 3 day Bowel and Bladder Log initiated 12-19-13 at 11:00pm. • Do no leave unattended on the toilet. • Toilet every two hours during night. This will continue until 3 day bowel and bladder assessment can be completed. • Pharmacy review of medications on 12/20/13 • Resident's Blood pressure and pulse will be monitored every 2 hours for one week to see if patterns noted with activity or time of day. • Sleep monitoring will be initiated after weekly blood pressure are completed on 12/27/13	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 78 the resident was wet at the time of the fall and the resident had been offered assistance with toileting at 4:00 p.m. and 7:00 p.m. but the resident had refused. During interview on 12/17/13 at 11:00 a.m. DON stated the intervention was to place a Dysum non slip pad to the residents wheelchair. DON verified this was the intervention put into place after the prior fall on 2/18/13. DON stated there was no further investigation as to why the Dysum was not in R32's wheelchair according to the plan of care. 3/13/13- 3:15 p.m. "Resident was found in her room on her hands and knees. She stated she gently slipped off her wheelchair and fell to her knees when she was trying to pick something up..." There was no indication if the anti slip cushion or Dysum was in the wheelchair. The summary of the fall indicated, "On 3/14/13 [Nurse Practitioner] was here for rounds and ordered a chest X-ray and various other orders due to increased confusion and decreased breath sounds." Review of the chest X-ray dated 3/14/13 indicated R32 was found to have "fracture of the left second through sixth ribs." Handwritten on the bottom of the X-ray by a [unknown] facility nurse was on 3/14/13 a message was left with R32's physician and NP, and on 3/15/13 a copy of the results were faxed to R32's physician and NP. However, there was no follow up note from the NP or physician, nor was there any assessment or investigation as to how R32 received four fractured ribs on the left side.	F 323	• Encourage resident to attend activities out of her room , especially in the evening hours to help promote nighttime sleep • Resident Community Life Assessment was reassessed 12/20/13. • Fifteen minute checks and hourly pendant monitoring will be reviewed by IDT for patterns, findings, and appropriateness of interventions. Changes to monitoring will be determined by the IDT based on the data collected. • Licensed staff will be responsible on each shift to ensure all staff is consistently implementing care planned interventions. • DNS and ED are responsible to ensure plan of correction completed. Correction will be complete by 1200 on 12/20/13. Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 79 During interview on 12/17/13 at 11:00 a.m. DON stated after the fall on 3/13/13 the NP saw R32 and ordered a chest X-ray related to decreased breath sounds. She stated the chest X-ray revealed R32 had 4 broken ribs, however, the facility had no investigation or communication with the NP or the physician regarding R32's broken ribs. DON stated R32 was diagnosed with pneumonia and was started on antibiotics and an Exelon (medication for memory) patch. No new specific fall interventions were implemented at this time. There was no indication that an assessment was completed to determine how R32 fractured her ribs, or if they were related to her multiple falls. 3/15/13- 7:10 p.m. "Resident was found by staff on the floor in her room. It appeared that resident had gotten up and was ambulating independently...Residents [family] does continue to want negotiated risk in place and would like resident to freely get up unassisted." During interview on 12/17/13 at 11:00 a.m. DON stated after the fall on 3/15/13 the facility completed a 3 day bowel and bladder diary and assessment. DON stated there was no pattern of voiding noted so the residents toileting schedule was to toileted every 3 hours and as requested by the resident. 3/18/13- 5:00 p.m.- "Resident was found lying on her left side on the floor of her room...Last time toileted was 'after lunch.' Resident was dry at time of fall." During interview on 12/17/13 at 11:00 a.m. DON stated she was not sure the specific time R32	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 80 had last been toileted before the fall on 3/18/13 as this was not part of the initial incident report investigation. DON verified no new interventions were implemented after the fall on 3/18/13. 3/27/13- 7:50 p.m. "Resident was found in her room, lying on her left side next to her wheelchair. Stated she put her newspapers on the floor, then knelt on the floor to pick them up and decided to lie down on the floor..." The investigation also indicated the residents phone was on the floor. The interventions put into place were, "Assess for proper placement of items resident may need; make sure they are within reach." During interview on 12/17/13 at 11:00 a.m. DON stated on 3/27/13 the facility nurses observed R32's room to ensure the "room setup" was appropriate for the resident. DON verified that included ensuring the residents call light is within reach, the tray table be placed in front of R32 with telephone, newspaper, pop/water, and remote control for the television on the table and within the residents reach. 3/29/13- 6:30 a.m. "Resident was found sitting with legs in bathroom and sitting with her bottom on the carpet in her room. Resident stated she was coming out of the bathroom and 'I sat down.'..Resident has it care planned and signed negotiated risk that no alarms or anything that would restrict her being able to move be in place." During interview on 12/17/13 at 11:00 a.m. DON stated no specific fall interventions were implemented after the fall on 3/29/13 because the resident had been refusing her Parkinson medications 2 days prior to the fall.	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 81 3/31/13- 3:45 p.m. "Resident was found sitting on the floor in her room next to her wheelchair and over-turned tray table... Assessed room for placement of items resident may be reaching for, rearranged appropriately." During interview on 12/17/13 at 11:00 a.m. DON stated she did not know what the resident was attempting to do nor was she sure how the residents room was arranged prior to the fall as this wasn't part of the assessment. The DON stated there were no specific fall interventions put in place after the fall on 3/31/13 because she thought the resident had been refusing some of her Parkinson's medications prior to the fall. The DON stated education was done with staff to ensure R32's call light was within reach, however, she was unable to verify why this education was completed as she was not sure if the resident had her call light near her at the time of her fall. 4/22/13- 6:30 p.m. "Resident was found by staff on the floor in her room. Resident was unable to describe what she was trying to do prior to falling. Resident was sitting with her back leaning up against the door to her room, her wheelchair was next to her in the upright position...last toileted prior to supper, 4:30 p.m., and was incontinent of bladder at time of fall. Have discussed use of alarms or interventions for falls with daughter, continues to wish to not have anything in place that could limit residents ability to transfer or move when she wishes to." During interview on 12/17/13 at 11:00 a.m. DON stated resident had been refusing medications prior to fall. She stated there was no further investigation or interventions implemented after the fall on 4/22/13.	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 82 5/1/13- 6:45 a.m. "Resident was found lying on her right side, up against the closet. Resident was unable to report what occurred or what she was trying to do prior to fall... last toileted at 5:30 a.m. and was continent at time of fall... Resident complained of right hip pain." The facility contacted the physician to obtain an X-ray which displayed a hip fracture and pelvis displacement. R32 was transferred to the hospital for surgery and returned on 5/4/13. The facility intervention after this fall was "assure resident is set up with appropriate items she may need (snack, magazine, etc.)." The X-ray results dated 5/1/13 identified R32 had a "right intertrochanteric hip fracture with up to roughly 6 mm (millimeters) of displacement... Fractures of the right superior and inferior pubic rami are again noted. There is increased displacement compared to prior exam. An associated sacral ala fracture is suspected but not identified with certainty." During interview on 12/17/13 at 11:00 a.m. DON stated the intervention was to make sure staff kept the residents 'items' within reach. DON stated the investigation did not include where items were placed in the residents room when she fell on 5/1/13. There was no indication the facility had comprehensively assessed R32 multiple falls from her wheel chair while she was in her room alone and implement appropriate interventions to decrease R32 risk of falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 83 5/22/13- 4:40 p.m. "Staff found resident lying on floor in her room on her right side...Resident had been repositioned by staff multiple times due to leaning in her wheelchair... NA staff member recognized resident was leaning forward in her wheelchair. The staff member repositioned her to a safe position, and then went to get assistance. When staff returned she was laying on the floor... When resident is displaying poor posture, staff are to assist her to bed." During interview on 12/17/13 at 11:00 a.m. DON stated the resident had refused her Parkinson's medications on 5/21/13, and staff was instructed to lay resident down in bed if she was leaning in her wheelchair. 6/1/13- 11:00 a.m. "Resident was found by staff sitting on her bottom near the bathroom, leaning on her elbows. Resident attempted to self-transfer and stated she slid very slowly to the floor...Resident was last toileted at 9:00 a.m., and was incontinent at time of fall... Resident is to be offered toileting every hour, re-education was provided to NA." The investigation did not identify where the resident slid from and if the anti slip cushion was in the residents wheelchair. During interview on 12/17/13 at 11:00 a.m. DON stated the resident refused her Parkinson's medications on 6/1/13. DON stated she was not sure if the residents anti slip Dysum was on her wheelchair cushion as that was not part of the fall investigation. 6/16/13- 5:15 p.m. "Resident was ground lying on her right side with legs bent to her chest. Was attempting to reach for something when she slid out of her wheelchair. Resident stated she was	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 84	F 323		

going to throw a piece of paper away and slid out of wheelchair. Was complaining of severe pain from left hip to upper right side of her body... ambulance was called... no fractures or other injuries. Educated family on use of anti-roll back brakes for the wheelchair which were applied at this time."

During interview on 12/17/13 at 11:00 a.m. DON stated anti lock brakes were added to R32's wheelchair after the fall on 6/16/13. DON stated she was not sure if the anti slip Dysum was in the residents chair as this was not part of the fall investigation.

8/18/13- 4:15 p.m. "Resident was found on the floor of her room by NA. Resident stated she gently lowered herself to the floor. Staff reports from that shift resident was leaning significantly through the shift. Staff approached resident multiple times to let down, but resident kept declining..."

During interview on 12/17/13 at 11:00 a.m. DON stated resident was educated to lay down while leaning in wheelchair.

8/25/13- 2:10 p.m. "Resident was found lying on the floor of her room after staff responded to her yelling 'help me!' When staff asked what she was doing she stated 'reaching to turn the stove off.' It appeared as if resident was previously in her wheelchair. Residents water pitcher noted to be on the ground and carpet was wet from water pitcher... discussed need for PT (physical therapy) or OT (occupational therapy) evaluation. Previous interventions continue from last evaluations which include anti roll back brakes. Family did not want to continue with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 85	F 323		

approaching resident every hour to offer toileting as this was making resident more anxious and confused. At this time therapy evaluation not felt to be appropriate."

During interview on 12/17/13 at 11:00 a.m. DON stated she was unsure when the intervention for R32 to be toileted every hour was put into place. However, she stated the resident and her family requested staff to not ask resident "so often" to go to the bathroom as the resident didn't like to be bothered that often. DON stated she thought at this time R32's toileting plan was changed to upon waking, before and after meals, and before bed. DON also stated she was unsure if the resident had fallen out of her bed or out of her wheelchair.

9/17/13- 4:40 p.m. "Resident was found on the floor by the NA. She was lying on her back and grasping her left hip. groin area and expressing severe pain...ambulance was contacted and resident was transported to the St. Cloud hospital. Prior to her fall activity staff had reported that she found resident standing in her room. She entered the room and had resident sit back in her wheelchair, and asked if there was something the resident needed. Resident pointed and stated, 'I need that over there,' though nothing was noted to be present...When found on the floor nurse asked what she was trying to do and resident stated she was trying to 'get out of here.' Resident had been asked at 4:00 p.m. if she needed to toilet but resident refused. Family had requested that no alarms be placed on resident as to not limit her mobility. Resident has anti-roll back brakes applied to her wheelchair, toileting plan in place and followed correctly." Resident returned to the facility from the hospital

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 86 on 9/19/13. Review of a Trauma Admission note dated 9/17/13 indicated R32 had a pelvis X-Ray which identified "evidence of old right hip fractures with new [acute] fractures of the left inferior pubic ramus and parasymphyseal region of the left pubic bone." R32 was admitted to the hospital. During interview on 12/17/13 at 11:00 a.m. DON stated the facility did not put new interventions in 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. There was no indication the facility had comprehensively assessed R32 multiple falls from her wheel chair while in her room and implement interventions to decrease R32 risk of falls. 11/9/13- 8:05 p.m. "Resident was found on the floor by NA sitting on the floor. Resident was sitting in front of her wheelchair...Resident was not incontinent at time of fall, but did void post fall. Staff did see resident ambulating in her room independently previously during the shift and did intercept resident. 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. the DON stated the Dycem non slip material which was ordered on 2/18/13 was never discontinued, and she was unsure it was not in the residents wheelchair on 11/9/13. DON verified staff were not following R32's care plan to prevent falls if the	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 87 Dycem was not in place. 11/27/13- 2:00 p.m. "NA found resident on floor between her nightstand and table in her room with back against the wall. Resident stated she was just walking around... had been toileted 30 minutes prior to the fall..." During interview on 12/17/13 at 11:00 a.m. DON stated no new interventions were implemented after the fall on 11/27/13 nor was the residents room set up included as part of the fall investigation. 12/6/13- 9:00 p.m. "Resident was found by NA on the floor of her bathroom... resident was not incontinent at time of fall and staff did assist resident to the toilet and she did void post fall. Resident had been approached by staff multiple times after supper to use the toilet and she declined each time." This information was listed on the summary of the fall, however, the actual investigation did not identify when the resident was last toileted. During interview on 12/17/13 at 11:00 a.m. DON stated R32's plan of care on 12/6/13 was to assist the resident to the bathroom every 2 hours, however, she was unaware when this toileting plan was implemented and when it was discontinued. DON stated R32 was also reminded to use the call light when she needed assistance. DON stated R32 was "sometimes" able to use her call light but was "inconsistent" with the use. The DON also verified none of the incident reports or the fall investigations include if the residents call light was on or within reach, and the resident will often propel herself in her wheelchair around her room, so her call light is	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 88 often not near her. The DON stated the facility had never talked about providing R32 with a pendent call light (one that could be worn around her neck), although the facility had the pendent call light system and several other residents in the facility were currently utilizing the pendent call light system. The DON stated staff needed to be more "aware" of R32 and the facility had talked about doing hourly rounds to ensure all residents safety, but this was not implemented for R32. The DON stated R32 had been seen by both PT and OT "off and on" for strengthening the last year. During interview on 12/17/13 at 2:15 p.m. R32's FM-I stated she was aware of the residents frequent falls and visits the resident often. R32's call light is often in different places and not within R32's reach. However, FM-I stated she wasn't sure the resident would always be cognitive enough to use the call light when she needed assistance. During interview on 12/18/13 at 1:10 p.m. physical therapist (PT)-H stated he had last worked with R32 towards the end of October 2013 for safe transferring. PT-H stated at that time it was recommended staff no longer walk R32 related to her instability and varying degrees of weakness from day to day. During interview on 12/18/13 at 1:05 p.m. NA-D stated R32 was to be toileted every 2 hours. NA-D stated R32 was supposed to have her bedside table in front of her with her remote control, phone, newspaper, and call light on. She stated the resident roams around her room so she often can not get to her call light when she needs it.	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 89	F 323		

During interview on 12/19/13 at 9:08 a.m. the occupational therapist (OT)-D stated she had worked with R32 on and off since May 2013. The OT-D stated in May 2013 she recommended staff toilet resident every hour because it appeared many falls were near the bathroom in the residents room. OT-D stated staff told her that family and R32 did not want the hour toileting because staff was "pestering" her to often. OT stated she then recommended to staff they should be doing at least hourly checks to ensure the resident was safe and had everything she needed. She was unsure if and when the one hour checks were implemented by the facility. OT-D stated she had anti lock brakes added to the residents wheelchair, but was not aware the resident had been sliding out of the wheelchair so R32's wheelchair cushion had never been reevaluated. OT-D verified if she was aware R32 had been slipping out of the wheelchair there are other cushions that could have been tried which may have prevented the resident from sliding out of the wheelchair.

During interview on 12/19/13 at 9:50 a.m. nurse consultant (NC)-C stated although the investigation documentation may not be complete, R32's falls were fully investigated. NC-C verified the facility provided all the documentation they had available related to R32's falls.

Even though R32 had 23 falls in the past 10 months, with some of the falls resulting in significant fractures which required hospitalization. The facility had not compressively assessed, or implemented consistent interventions to decrease the risk of falls for R32.

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 90	F 323		

R48 had six falls, from 10/7 thru 11/24/13, in which she sustained multiple head injuries with significant changes in her vital signs and neurological exam. The facility did not comprehensively assess her falls and consistently implement interventions to decrease her risk for falls, which resulted in an immediate jeopardy for R48.

R48's admission Minimum Data Set (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 activities of daily living (ADL's), 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, care planning would occur due to these risks.

R48's Fall Risk Assessment dated 10/7/13, identified risk factors for falls, including use of antihypertensives medication, a blood pressure was included of 166/67, however, there was no indication an orthostatic blood pressure (blood pressure taken while lying, sitting, then standing) to determine if there was a drop in blood pressure with position changes (an orthostatic change), a potential side effect of antihypertensives medication, which can lead to feeling dizzy or lightheaded and cause a fall.

R48's Progress Notes dated 10/7/13, indicated a TABs (a personal alarm system that attaches to a person and sounds when they attempt to get up) and a sensor pad had been initiated to alert staff

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 91	F 323		

when R48 attempts to get up on her own.

R48's care plan dated, 10/24/13, included, "[R48] is at risk for falls r/t [related to] history of, cognitive loss with impaired decision making, incont [incontinent], new to environment, daily analgesia use, and osteoporosis." The care plan directed staff to ensure call light was in reach, keep bed in low position, anticipate needs, and to, "Review information on past falls and attempt to determine cause of falls. Document. Alter remove any potential causes if possible. Educate resident/family/caregivers as to causes." The care plan included a focus of hypertension and directed staff to, "Give anti hypertensive medications as ordered. Observe for side effects such as orthostatic hypotension [a drop in blood pressure of more than 20 points with position change] and increased heart rate (Tachycardia) and effectiveness. Observe/document/report to medical practitioner PRN [as needed] any s/sx [signs or symptoms] of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea)."

An undated Nursing Assistant Care Plan, directed staff to leave walker in place, perform 15 minute checks, and keep bed at appropriate transfer height.

R48's Resident Incident Report dated 10/27/13, at 11:25 a.m. indicated R48 was found sitting on the floor next to her bed. Her blood pressure (normal blood pressure 120/80 mm [millimeters] hg [mercury]) reading at the time of the fall was 203/82 mm hg lying and 167/76 mm hg while sitting, a standing blood pressure reading had not

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 92 been obtained. There was a 36 points drop in blood pressure which was significant, along with both blood pressure reading were elevated. The next documented blood pressure was located in R48's electronic record under Progress Notes dated 10/28/13, at 5:07 a.m. of 183/76 mm hg, still elevated over 17 hours later. The next blood pressure was found in the electronic record under Vital Signs, dated 10/29/13, a day later, of 144/76 mm hg. No further orthostatic blood pressures had been recorded. An Incident Investigation report dated 10/27/13, indicated the alarm system being used had malfunctioned and did not alert staff for, "At least 10-20 second delay over the walkie system." There was no indication the alarm system had been repaired or replaced, despite having a delay. The Incident Investigation also included, "Plan to prevent further falls is to leave bed at appropriate height so resident is not trying to stand from low bed position and to assure walker in reach so if resident attempts to get up she is safer," which was added to the care plan. R48's Resident Incident Report dated 11/2/13, at 12:00 a.m. indicated R48 had fallen in her room, her blood pressure was 215/81 mm hg at the time of the fall. R48 had hit her head during the fall and complained of head pain. A Neurological Assessment Flowsheet had been initiated, which included frequent blood pressure checks for the next 24 hours and an orthostatic blood pressure reading had not been recorded. The blood pressure at 12:30 a.m. on 11/3/13, was 176/70 mmHg. In addition, the Neurological Assessment Flow Sheet indicated R48 had complained of head pain on 11/2/13, at 12:05 a.m. and again at 3:50 a.m. The next documented blood pressure	F 323		

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 93	F 323		

was located under Vital Signs in the electronic record dated 11/5/13, at 10:29 a.m. three days after the fall and continued to remain high at 187/78 mm hg. There was no evidence in the medical record an orthostatic blood pressure had been completed, or the blood pressures and head pain had been monitored and reported to the physician. In addition, the Incident Investigation report dated 11/2/13, also indicated R48's bed was in the lowest position, not at transfer height as directed by the care plan. The investigation did not include if R48's walker had been within reach or not.

When interviewed on 12/19/13, at 2:50 p.m. the DON stated, a new intervention of offering to toilet every two hours at night had been initiated. Keeping her bed at the proper height was added to the Nursing Assistant Care Plan (a paper nursing assistants carry, which directs care for each resident), which had not been added until the 11/2/13 fall.

R48's Resident Incident Report dated 11/8/13, at 12:30 a.m. indicated R48 had fallen in her room, hit her head, and sustained a 3 centimeter (cm) by 4 cm hematoma (large collection of blood under the skin) on the back of her head. R48's blood pressure at that time was 199/84 mm hg lying and 181/84 mm hg sitting. A Neurological Assessment Flow Sheet had been started and were completed every four hours for 24 hours. At 4:00 a.m. R48's blood pressure remained elevated at 199/75 mm hg. The final blood blood pressure at 12:00 a.m. on 11/9/13 was 167/72 mm hg. The Neurological Assessment Flowsheet noted R48's bilateral pupils were equal, round, and reacted to light normally until 8:00 a.m., when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 94 they became sluggish in reaction to light (possible indicator of brain trauma) and continued to remain sluggish until the neurological exams stopped at 12:00 a.m. (24 hours after the fall). A progress note dated 11/8/13, at 11:10 a.m. noted R48 complained of a head ache, and had vomited after breakfast. R48's relative had been 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 her, "Pupils are sluggish with reaction, but nurse had noted this prior to fall." A Progress Note dated 11/8/13, at 1:40 a.m. indicated an on call physician had been contacted about the fall. There was no evidence the physician had been notified of the elevated blood pressures, head injury, or changes in pupil reaction to light. Staff were re-educated to make sure her walker was by bed. The Incident Investigation report dated 11/8/13, included, "In discussion with staff they were asking resident every two hours if she needed to void on the night shift. Staff was educated that we should be encouraging resident to toilet every two hours at night." The investigation failed to identify when R48 had been assisted to the toilet last, or if the walker was in reach and the bed at the appropriate height. R48's Resident Incident Report dated 11/13/13, at 1:30 a.m. included she had fallen in her room at the foot of the bed and hit her head. R48's blood pressure at the time of the fall was 214/80 mm hg lying and 168/89 mm hg sitting, a 46 point drop. A Neurological Assessment Flowsheet had been started for the next 24 hours with blood pressure	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 95	F 323		

readings between 114/55 mm hg to 168/89 mm hg, and initial complaints of a head ache. No further orthostatic blood pressures had been completed. 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. The Incident Investigation report indicated R48's walker had not been within reach as directed by the care plan. The report included, "Re-educated staff on leaving walker within reach and on approaching resident's toileting. Educated them to encourage her to toilet and if she refuses have another staff member reproach her and off [sic] toileting." There was no assessment to determine if the drop in blood pressure would be a possible cause in R48's fall, nor were there any interventions added to help prevent further falls and injury for R48.

R48's Nurse practitioner (NP) Nursing Home Rounds report dated 11/22/13, included a physical exam by the NP. The NP notes included, "I do not have weights or vital signs to review, but I am not made aware of any problems." The NP also noted, under Assessment, "Hypertension, but I am not aware of any problems." There was no evidence staff had reported any of the elevated blood pressures or drop in blood pressures with position changed at the time of the falls, or changes in R48 neurological condition with the 11/2, 11/8 and 11/13/13 falls.

R48's Resident Incident Report dated 11/24/13, at 10:25 p.m. indicated R48 had fallen and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 96 stated she "bumped" her head and had complained of left hip soreness. R48's blood pressure at that time was recorded as, 210/83 mm hg sitting. A Neurological Assessment Flowsheet had been started and were periodically checked over the next 24 hours, blood pressures were recorded between 113/61 mm hg and 200/83 mm hg, pupils were recorded as either non-reactive or sluggish. A Centracare Clinic Fax was sent to the physician describing the fall, but had noted only a blood pressure reading of 161/66 mm hg. There was no evidence the physician had been notified of the 210/83 mm hg and 200/83 mm hg readings, or the non-reactive or sluggish pupils R48 was experiencing as a result of the fall. There was no monitoring of orthostatic blood pressures during this time, even though R48 had a history of an orthostatic drop in blood pressure. A Progress Note dated 11/24/13, at 9:07 p.m. indicated the fall had actually occurred at that time, and R48 had received a red mark on her left cheek. The Incident Investigation dated 11/24/13, indicated R48 was attempting to go to the bathroom, but had been assisted to the bathroom at 10:00 p.m. The report failed to identify if R48's walker was in reach, or if the bed was at the appropriate transfer height, or if she had been assisted to the bathroom prior to the fall. There were no indication additional interventions were added or changed to help prevent further fall. R48's Resident Incident Report dated 12/10/13, at 9:20 a.m. indicated R48 had been left in the bathroom on the toilet alone and had fallen. R48 had hit her head again and received a "4 cm [centimeter] by 4 cm reddened area to middle of back with tiny abrasions." The Incident	F 323		

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ___ B. WING ___	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 97 Investigation report indicated staff were re-educated on not leaving R48 unattended on the toilet because of her impulsive behavior. R48's medication administration record (MAR) indicated the reddened area on her back with abrasions remained until 12/15/13. R48's Nursing Home Rounds by the physician dated 12/11/13, included, "She had a minor fall on November 8, 2013, without sequelae [without complication]; also on October 28, 2013. Under physical exam the note included, "For technical reasons, her blood pressures and weights are not available." There was no evidence the physician was informed of the head injury sustained on 11/8/13, 11/13/13 and 11/24/13 with the symptoms of vomiting, head pain, drop in blood pressures with position change, declining neurological condition with change in pupil reaction, and head aches as part of the neurological assessments. Also, there was no indication the physician was informed of the elevated blood pressures following each falls which occurred on 10/27, 11/2, 11/8/13, 11/13, and 11/24/13. When interviewed on 12/19/13, at 2:50 p.m. the DON stated it is the facilities policy not to leave unsteady or cognitively impaired residents alone in the bathroom. She had re-educated the nurse aide responsible at the time of the fall on 12/10/13. The DON stated staff should have continued to monitor and notify the physician of elevated blood pressures, drop in blood pressures with position change, declining neurological status, and head injuries. In addition, the DON stated the fall investigations	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 98	F 323		

should have included if the the bed had been at the proper height or if the walker had been within reach, staff should have attempted to determine cause of the falls and added interventions to aide in further fall prevention.

During interview on 12/19/13, at 4:47 p.m. licensed practical nurse (LPN)-A stated R48 forgets to put on her call light and will try to transfer herself once or twice a day, attempting to go to the bathroom.

When interviewed on 12/19/13, at 4:49 p.m. nursing assistant (NA)-L stated R48 attempts to transfer herself once or twice a week. R48 is not to be left alone in the bathroom. NA-L did not know what height R48's bed was suppose to be in, or where her walker was suppose to be located.

During interview on 12/19/13, at 5:00 p.m. R48 stated the "girls," help her to the bathroom. Otherwise she was not oriented to time or place. R48 was in bed, the bed was in a low position and her walker was across the room by the entrance door, not by her bed.

When interviewed on 12/19/13, at 5:05 p.m. NA-K stated R48 is not to be left in the bathroom alone, her bed is suppose to be, "a little down." This would be if sitting on the edge of the bed, R48's feet should touch the floor. After consulting the Nursing Assistant Care Plan, NA-K stated R48's walker should be within reach, and verified it was not.

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 99	F 323		

R48 had six falls, from 10/7 thru 11/24/13, with elevated blood pressures at the time of the falls, blood pressures which dropped significantly with a position change, declining neurological symptom, head aches, and vomiting following head injuries which the physician was not informed of. The facility did not comprehensively assess her falls, and consistently implement interventions to help decrease her risk for falls.

An undated facility policy of Change in Condition, When to Report to the MD/NP/PA form identified that systolic blood pressures over 210, diastolic over 115 immediately, and diastolic routinely over 90 the next day are reported to the physician. The form also indicated the need to contact the physician if the resident sustained a contusion associated with a recent fall with no other complications, and to send to the emergency room immediately for a fall with head injury. The form further indicated to report immediately falls with any suspected serious injury, any hip pain, and to report routinely number of falls in patient since last visit.

The immediate jeopardy that began on 12/19/13, at 6:00 p.m., was removed on 12/20/13 at 2:00 p.m. when the facility completed a falls reassessment of R42, R38 and other residents who had a fall within the past 6 months to ensure appropriate interventions were in place; all staff were re-educated prior to beginning work regarding specific fall interventions to ensure correct implementation of the care plan, care plans were updated, and implementation of frequent checks and monitoring were completed for all resident with identified falls, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 100 noncompliance remained at an isolated scope and severity level, of actual harm that was not immediate jeopardy. R11's had multiple falls which were not compressively reassessed, to determine appropriate interventions to help decrease the risk of falls. R11's current annual MDS dated 10/16/13, indicated she was moderately cognitively intact, needed extensive assistance with transfers, and ambulation. The MDS indicated R11 had no falls since prior assessment of 10/9/13 and was frequently incontinent of bladder. R11's admission Care Area Assessment (CAA) dated 10/16/13 indicated she had a potential for falls and fell 30 days prior to admit, was on a diuretic (water pill), frequently incontinent of urine and had a history of frequent falls in addition to intentional position changes. R11's falls assessment dated 10/10/13, indicated she received diuretics (medication to decrease fluid), inadequate vision, frequently incontinent of urine, had loss of balance while standing, requires hand on assistance to move from place to place, had falls 30 days prior to admit. The assessment summary indicated she was alert and disorientated with a recent history of frequent falls in addition to intentional position changes. R11's bladder assessment dated 10/10/13, indicated she was frequently incontinent of urine, requires assist with ambulation and transfers, received diuretics. The assessment indicated she showed most continence during waking hours and sporadic incontinence at night, she did not respond to 1.5 hour toileting and they are	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 101 assisting her to the toilet every two hours with staff returning 10 minutes later and as needed. R11's current care plan dated 10/13/13, indicated she was at moderate risk for falls related to unaware of safety needs, short term memory loss, gait/balance problems and bladder urgency with incontinence. The care plan direct staff to toilet R11 every three hours and return after 10 minutes if refuses with assistance of one for transfers and toileting. R11 had a low bed with a fall mat, pressure-sensor pad in her bed, and a tabs (personal safety) alarm in her chair. R11's nursing assistant care plan (undated) indicated R11 had a sensor pad in her bed, low bed, floor mat next to bed, non-slip in wheelchair, anti rollbacks on wheelchair, alarm on wheelchair and to toilet every 3 hours during the day and 2 hours at night and to return in 10 minutes and check if needing to toilet again. During observation 12/16/13, at 5:30 p.m. R11 was observed in her room , sitting in her wheelchair with tabs (personal alarm) attached. During observation on 12/18/13, at 7:03 a.m. R11 was asleep in her bed which was in the low position with a sensor alarm on. R11 was observed on 12/19/13, at 10:30 a.m. sitting in her room next to her desk, with alarm attached to her wheelchair. Review of R11's Resident Incident Reports dated from 7/23/13 to 11/24/13 identified multiple falls, four falls were related to staff not following R11's care plan as follows: The incident report identified on 8/22/13, at 2:35 a.m. R11 was found on a fall mat sitting next to her bed. The falls investigation indicated staff had not toileted R11 on the night shift, they checked R11 every two hours and asked her if she needs to use the toilet but didn't get R11 up if she says no or re-offer the bathroom later. Staff	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 102 did not follow the care plan and were re-educated. The incident report identified 9/30/13, at 4:45 a.m. R11 was found on floor mat next to her bed. The fall investigation indicated resident had last been toileted at 2:00 a.m. and during interview with nursing assistant she checked her pad at 4:00 a.m. but did not go back and check to see if she needed to use the toilet. Staff did not follow the care plan and were re-educated. The incident report identified on 11/4/13, at 5:00 a.m. R11 was found on the floor in her room. R11 was left alone on the commode and was found 10 minutes later on the floor. Staff did not follow the care plan and were educated not to leave resident unattended on the commode. The facility incident report identified on 11/24/13 at 6:20 a.m. R11 was found on the floor next to her bed, sitting on the floor mat. R11 had been toileted at 2:45 a.m. and denied need for toileting on rounds at 4:00 a.m. The resident's call light was on and she was incontinent of urine but used the commode post fall. R11 stated she was getting up to use the toilet. Staff were re-educated about appropriate call light response time and toileting plan as identified by the care plan. Although R11 had four falls in her room during the early morning hours, form 2:00-6:00 a.m. there was no indication the facility had compressively reassessed R11 falls, to determine appropriate interventions to help decrease her risk of falls besides re-education of the staff involved with R11 care.	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 103 During interview 12/19/13, at 9:03 a.m. with occupational therapist (OT)-A stated she was aware R11 had falls and had offered to re-evaluate R11 but was informed by staff the falls were isolated and didn't feel it was necessary. The falls were reviewed with the OT-A, and stated the falls were related to toileting during the night shift. OT-A would recommend the staff reassess R11 bladder incontinence and update her toileting times more frequently. The OT-A further stated that R11 should not be left alone on the commode. During interview 12/19/13, at 10:00a.m. RN-A stated R11's bladder assessment indicated she has sporadic incontinence at night and had tried toileting every 1.5 hours but her continence had not improved. RN-A verified R11 had multiple falls during the night shift related to toileting and had not reassessed her toileting plan looking for patterns with incontinence and her falls. During interview 12/19/13, at 10:30a.m. the DON verified the falls were related to staff not following R11's care plan on the night shift with toileting. The DON stated she educated the staff but was unable to recall which staff were re-educated to determine if it was a pattern of a certain staff. The DON further stated R11's toileting plan should have been reassessed and updated in attempt to reduce R11's falls. R66 falls were not comprehensively assessed to determine appropriate interventions to help decrease risk of falls. R66 care plan updated 12/16/2013, identified diagnoses of hypertension, unspecified cardiac dysrhythmia, incomplete bladder emptying, and unspecified anxiety state. The 14-day Minimum	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 R66'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 reminders 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 of 2 for transfers with weight bearing 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 fall 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 an unwitnessed fall, and R66 was unable to tell staff what he was doing. The cause of the fall indicated "Resident did have irregular pulse", and listed as intervention to prevent future falls, "...must sit for all toileting needs to prevent possible vasovagel response."	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 105 During an interview on 12/19/2013 at 12:11 p.m., nursing assistant (NA)-B stated R66 required limited assistance with activities of daily living (ADLs), and was able to express his needs. NA-B was certain R66 could use a call light, and stated the care plan indicated he can be left alone in the bathroom, but "I just stay with him in the bathroom because he is so quick." NA-B also said R66 requires help with transfers and needs weight bearing assistance, and has "really made progress" since admission to the facility. During an interview on 12/19/2013 at 9:10 a.m., licensed practical nurse (LPN)-A stated R66's cognition "fluctuates", and "has dementia". When asked how it was determined if it was ok for R66 to be left alone in the bathroom, LPN-A stated that "...[R66] does self transfer, and if he would have a TABS alarm [brand name safety alarm] assigned, then he would not be safe to leave alone." LPN-A said right now he "does not have" a TABS alarm. During an interview on 12/19/2013 at 8:50 a.m., LPN-D, did not know if R66 was safe to be left alone in the bathroom. During an interview on 12/19/2013 at 8:59 a.m., the certified nurse practitioner (CNP) stated R66, "Was getting lost in familiar places recently", and had signs and symptoms of increasing dementia. The CNP stated that R66 has bradycardia, which, "May be a trigger for falls." In an interview on 12/19/2013 at 2:45 p.m., the director of nursing (DON) said she responded to R66's fall incident of 12/11/13 and R66's doctor felt R66's bradycardia was the root cause of the fall, and suggested R66 complete, "All toileting needs seated." The DON said that intervention were added to the nursing assistant care sheets for R66. The DON felt R66 was safe to be left alone in the bathroom, but verified the facility did	F 323		

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	245375		12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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 analysis: This checklist reviews the residents history of falls, internal and external risk factors including; sensory impairments, medical conditions, medications, physical function impairments, behaviors and environmental risk factors for falling. Risk factors for increased potential for injury are also identified to assist in developing an appropriate plan of care for fall and injury reduction. Each identified area should trigger an intervention... The resident plan of care which identifies; the fall history. The residents risk areas consistent with specific conditions, needs, behaviors, and preferences. If the resident refuses or resists interventions, the care plan reflects efforts to seek alternatives to address the needs identified... A fall risk analysis is required after any fall in/out of the facility...The completed incident report, falls risk analysis, and internal investigation are reviewed by members of the Interdisciplinary Team (IDT) after any fall...The administrator and nursing services are responsible to ensure the facility adheres to the	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 107 Incident reporting policy and procedure including to determine whether the accident/ incident was preventable and/or reportable to... the MM Department of health according to Federal and State Regulations...Interventions: A history of falls is the most important predictor of future falls. Appropriate prevention measures should be initiated at admission. List all interventions on the care plan and the nursing assistant assignment sheet. Consider PT/OT assessment. Medication review by pharmacist. Environmental review. Assistive devices such as a seat belt, change of foot wear, lap buddy, anti roll back devices, non skid products for seating and floors, and anti tip bars on wheelchairs, etc. Protective devices such as helmets, hip protectors, chair/ bed alarms, fall mats, high/low beds, floor mats, booster pillows, etc. Additional monitoring for toileting needs, infections, drug reactions...must monitor the fall log routinely to assure that all falls have been logged and an appropriate intervention is documented in the fall log, on the care plan and the nursing assistant assignment sheet for each fall... Nursing service is responsible for monitoring falls for patterns of time, locations and activity to determine appropriate staffing levels and necessary supervision."	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353	F353 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 108 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staffing patterns were sufficient to provide timely assistance to meet resident needs, for 9 of 41 residents (R51, R9, R6, R18, R12, R20, R13, R24 and R25) in the facility who were identified with and/or identified in concerns of insufficient staffing. Findings include: R51 had to wait long periods of time to be assisted with incontinent pad changes, which caused her discomfort. R51's annual Minimum Data Set (MDS) dated 10/8/13, included a diagnosis of quadriplegia (paralysis of all limbs). R51 was cognitively intact, showed verbal behaviors towards others one to three days out of the assessment week, required extensive to total staff assistance for all activities of daily living (ADLs), and was always	F 353	1. Call light report will be reviewed for each day for one month. 2. 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 interview 3. The data collected will be presented to the QA Committee by the ED/DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ___ B. WING ___	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 109 incontinent of bowel and bladder. When interviewed on 12/17/13, at 11:00 a.m. R51 stated she often had to wait for extended periods of time, sometimes up to one hour, when she needed assistance with something. R51 stated she was paralyzed and unable to do anything for herself. She added, "The aides are always rushed, they say they are working short, it makes me feel bad for needing so much help." During a follow-up interview on 12/19/13, at 10:00 a.m. R51 stated she became upset because it took so long for someone to answer her call light. She indicated sometimes the wait was up to an hour. R51 stated the longest wait times were after supper, and then after midnight until morning. R51 stated, "The aides say they are short staffed, and they rush through helping me. I feel bad they are short, but I have to wait to get a drink of water, or get my pad changed." R51 then stated, "Now I know why a baby cries when their diaper is wet." R51 stated she began to "holler" out when she had to wait a long time. She reported that hollering out was more effective to get a response, but she then was told she had to be patient because the staff were working short. R51's call light logs from 11/18/13, through 12/18/13, revealed her call light had been activated for over 25 minutes, on 18 occasions during the month long period. All of the wait times were between 5:55 p.m. and 12:15 a.m. On 12/6/13, at 7:11 p.m. her call light wait was 61.2 minutes. On 12/8/13, at 7:02 p.m. her call light wait time was 58.5 minutes. R51's care plan dated 10/9/13, indicated she was at high risk for pressure ulcers related to	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 110	F 353		

incontinence and dependence upon staff for cares. The care plan also indicated she had behavior problems related to calling out for assistance after she turned on her call light. The care plan directed staff to, "Monitor call light times as appropriate."

When interviewed on 12/19/13, at 8:30 a.m. the director of nursing (DON) explained, "Monitor call light times as appropriate," meant if R51 complained of excessive call light response times, she would review the call light logs. If there were any long wait times she checked with staff to see why the waits were so long. Aside from this, the DON verified she had not made attempts to correct the long call light times. She had not checked these call light logs recently, despite having been aware that R51 has expressed concerns about long waits.
R9 reported she did not receive her bath due to insufficient staffing, which was corroborated by employee interviews.

R9's quarterly MDS dated 10/4/13, included diagnoses of anxiety and depression. The MDS indicated R9 required supervision and set up assistance with bathing.

During interview on 12/16/13, at 4:17 p.m. R9 stated she did not receive her bath on Saturday morning due to short staffing. R9 then stated this had happened to her several times in the past few months. R9 stated, "I would give myself a bath but I am afraid to go into the tub alone."

During interview on 12/19/13, at 11:00 a.m. nursing assistant (NA)-C stated she did not give R9 her bath Saturday morning because they were short staffed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 111 During interview on 12/19/13, at 11:30 a.m. NA-B stated R9 missed her bath last Saturday do to short staffing. NA-B added that a bath was offered later in the day, but R9 refused because she preferred to bathe in the morning. R6 stated the facility did not have enough staff to provide timely assistance for toileting. R6's quarterly MDS dated 10/15/13, identified the resident had no cognitive impairment and was totally dependent on staff for all ADLs except eating. During interview on 12/16/13, at 4:20 p.m. the resident stated she had to wait "so long" to be assisted to the bathroom that she had to go to the bathroom in her brief. R6 stated it had been over an hour at times that she had to wait to receive assistance. R6 reported the evening after supper time seemed to be the longest response times. R6 stated she had complained "many times" regarding having to wait to be assisted to the bathroom. R6 stated, "I hate sitting in my poop and pee!" During interview on 12/17/13, at 8:20 p.m. NA-L stated that one evening, several weeks prior, R6's call light had been on for over 45 minutes but no one had gone in to help her. NA-L then stated that although she was not assigned to R6 that evening, she finally went and assisted the resident to the bathroom because she felt "bad" no one had helped her for such a long period of time. Furthermore NA-L stated she had not spoken to anyone else regarding this concern. The facility did not respond appropriately to resident council concerns related to sufficient	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ____ B. WING ____	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 112 staffing, as evidenced by resident council meeting minutes and interviews with resident council members for 7 of 41 residents (R18, R12, R20, R13, R6, R24 and R25) who regularly attended the resident council meetings. Refer to F244 for additional information. There was 1 of 3 family members (FM)-J interviewed had complaints the facility did not have enough staff to answer calls lights timely. During interview on 12/16/13, at 4:30 p.m. FM-J stated she visited the facility daily and the facility seemed to "always" be short staffed. She stated her family member often did not get water related to the facility being short staffed. FM-J stated her family member had called her several weeks ago at 6:00 a.m., because she had her call light on and the staff kept coming in and turning it off, saying they would come back to assist her to the bathroom, but they never came back. FM-J stated her family member was able to tell staff when she needed to go to the bathroom; however, she often had to wait for so long to be assisted related to short staffing that she would go in her brief and have to sit in it. There was 4 of 7 nursing assistants (NA-C, NA-,F, NA-C, NA-L, NA-D) that complained there was not sufficient staffing to complete there work timely. During interview on 12/17/13, at 8:10 p.m. NA-N stated the evening shift was "usually" short. She stated the NAs did their best to provide the residents with the care they needed, but at times it took "a while" to answer call lights. At 8:40 p.m. NA-N stated the evening shift is "always" short staffed. She stated the staff does their best to	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 113 provide the necessary cares for the residents, and it can take a long time to answer call lights, especially on the East side of the building. NA-N stated if there were extra cares that needed to be done on the evening shift, such as baths, those often could not be completed because there was not enough staff. During interview on 12/17/13, at 8:20 p.m. NA-L stated the evening shift was "always" short staffed. She stated she knew residents complained of long waits to have their call light answered, but the NAs did the best they could. At 8:50 p.m. NA-L stated staffing at the facility had been short on all shifts in the last "few months," but more so during the evening shifts. NA-L stated the schedule was posted and the facility did not have enough NAs for the shift, so either they had to work short staffed or someone who had already worked eight to ten hours was mandated to stay, which was not very helpful. During an interview on 12/19/13, at 8:49 a.m., NA-C stated generally, "[The] p.m. shift could use more staff," as there seemed to be long call light times during that shift. NA-C stated, she felt there were times that resident falls occurred, which "could have been avoided" with more staff availability. NA-C said she recalled that a resident, R16, recently had a fall, a "fall from the toilet." NA-C said she was working that day and was assisting another resident when she noted R16's light went off. She stated, "After [R16] fell, I felt responsible." During an interview on 12/19/13, at 12:37 p.m., NA-F stated she did not think there was enough staff, especially on the evening shift which was "very rushed." NA-F stated she was unable to	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 114 complete all resident cares, "like repositioning, but I do not leave until all cares are done so I never am out by 8 p.m." She added, "I don't know what others do." During an interview on 12/19/13, at 12:44 p.m., NA-D stated, "Some days there is not enough staff, with our care load we could use more. There are a lot of call-ins on days and p.m. [shifts]. It gets frustrating." NA-D further stated, "Baths can get pushed back when we get call-ins. We will not give someone who has two baths a week their second bath instead of not bathing someone who gets one bath per week."	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	F356 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 115 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required information for nursing hours on a daily basis at the beginning of each shift. This had the potential to affect all 41 residents residing in the facility and all visitors. Findings include: During initial tour on 12/16/13, at 12:00 p.m. the facility staff posting dated 12/15/13, was posted on a bulletin board outside the nursing station. Although the name of the facility, date and census were included in the posting, the total number of licensed and unlicensed staff and hours worked were not identified for each shift. For the 6:00 a.m. to 2:30 p.m. shift, the posting indicated there were two licensed practical nurses (LPNs) and four nursing assistants (NAs). The posting did not list the total hours worked. During interview on 12/16/13, at 4:30pm the director of nursing (DON) stated the 12/16/13 posting was in her office and not posted on the bulletin board. The DON verified the total number of hours worked was not on the staff posting, nor was it on the last two weeks of the staff postings	F 356	4. Medical Records or designee will create posting, night RN will post daily 5. Audits will be done daily for 2 weeks, than weekly for two months 6. The data collected will be presented to the QA Committee by the ED/DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: ~~February 17, 2014~~	1/24/14 See addendum /HB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 116 reviewed. A facility policy on the staff posting was requested but not provided.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F 441 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. Nursing staff education to be completed on proper hand washing and gloving procedures by January 24, 2014 2. The DNS and/or her designee will complete 5 audits per week for one month than 3 audits a week for two months on random staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 117 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to minimize the spread of infection after staff provided personal cares for a resident (R16), and then did not wash hands prior to providing assistance for a compromised resident (R47) during 1 of 9 observations of routine care. Findings include: During observation on 12/18/13, at 8:25 a.m. nursing assistant (NA)-D provided routine morning cares for R16 in the resident's room. NA-D groomed R16's hair, performed oral cares, washed R16's face with warm wash cloth, and partially dressed R16. Next, NA-D provided R16 with perineal care, and removed and disposed the soiled gloves. NA-D then dressed R16, and, with NA-C, transferred R16 to a wheel chair. NA-D neither washed hands with soap and water, nor used an alcohol-based hand sanitizer at any time upon entering, while performing cares, or prior to leaving R16's room. On 12/18/13, at 8:37 a.m. NA-D exited R16's room and immediately entered R47's room to answer the resident's call light. NA-D did not wash hands prior to entering R47's room, whom had contact precautions in place. Upon entering R47's room, NA-D adjusted the placement of the call light, interacted briefly with the R47 then	F 441	3. The data collected will be presented to the QA Committee by the DNS. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA Committee will make the decision/recommendation regarding any follow-up studies. Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 118 exited the room. NA-D did not wash hands or use sanitizer after providing assistance to R47 or when leaving the residents room at 8:39 a.m. R47's diagnoses, as indicated from the admission Minimum Data Set (MDS) dated 7/17/2013, included quadriplegia, presence of Stage 2 pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. R47 also had pressure ulcers and pneumonia. The MDS also indicated R47 was cognitively intact, had an indwelling, suprapubic catheter, and was totally dependent upon staff to meet daily needs. The record identified R47 had Clostridium difficile, a bacterial infection, in which contact precautions were being implemented. In an interview on 12/18/13, at 9:02 a.m. NA-D acknowledged after providing perineal care to R16 she did not wash her hands or use a hand sanitizer prior to entering R47's room to provide assistance. NA-D stated "I just got so into it," and did not even realize I did not wash my hands and "I should have washed my hands" before going into another room. NA-D stated she was aware R47 "had C-diff" and "special precautions" were in place for R47 related to the C-diff infection. NA-D stated she had infection control training when hired, and "we get reminders often, especially about handwashing." During an interview on 12/18/13, at 10:36 a.m. the director of nursing (DON) stated staff should wash their hands between rooms when working with residents. The DON also stated there were inservices throughout the year for the all staff and the facility completes random audits to ensure hands are washed before and after cares for all residents. DON stated that [handwashing] was	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING ______ B. WING ______	12/20/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 119 "essential to providing safe, resident care." In an interview on 12/19/13, at 8:12 a.m. assistant director of nursing (ADON), also the facility infection control nurse, stated nurses and staff "should be washing hands" after doing peri-cares for a resident, and prior to entering another room and beginning cares for a different resident, especially to prevent transmission to any "compromised" resident, such as R47. The ADON verified R47 was currently receiving antibiotic treatment, and "had C-diff." The ADON also said routine and frequent handwashing after providing resident cares was "reviewed and reiterated often, especially with the aides." The facility Handwashing Policy and Procedure, dated 1/10, directed staff when it was appropriate to use alcohol-based hand sanitizers, and when and how to wash hands with soap and water.	F 441		

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

F5375023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 02 - 2010 ADDTION B. WING ______	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Fire Safety: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, Sterling Park Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok FS 1-30-14 RECEIVED JAN 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-29-14
EXIT: 12-20-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 1-27-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **02 - 2010 ADDTION** B. WING ______	**12/19/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us 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. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two buildings due to the construction dates of the buildings. The Courtyard Great Room addition (bldg #2) is a 1 story addition without basement. The building was constructed in 2010 and was determined to be of Type II(111) construction. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a licensed capacity of 60 and had a census of 40 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 050 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **02 - 2010 ADDTION** B. WING ______	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 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 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct 4 of 12 required fire drills as required by the NFPA 101 Life Safety Code (00) section 18.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 40 residents, visitors and staff. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, during a documentation review of the available fire drill reports for the last 12 months and interview with the Director of Maintenance (JC), it was revealed that the facility failed to conduct 2 fire drills in the second quarter, and 2 fire drills in the 3rd quarter of the calendar year. This deficient practice was verified by the Director of Maintenance (JC)	K 050	1. As of 8/28/2013, the Director of Maintenance has completed the drills according to fire and life safety code. We have preformed a drill on all shifts. We have completed and will continue to complete these drills on a regular basis and in accordance with fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the drills are being done and documented correctly according to fire and life safety code. 3. 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 Completion date: January 24, 2014	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052	K 052 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 02 - 2010 ADDTION B. WING	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, during a documentation review of the 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)	K 052	Without waiving the foregoing statement, the facility states with respect to: 1. As of 8/28/2013, the Director of Maintenance has completed the drills according to fire and life safety code. We have preformed a drill on all shifts. We have completed and will continue to complete these drills on a regular basis and in accordance with fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the drills are being done and documented correctly according to fire and life safety code. 3. 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 Completion date: January 24, 2014 K 062	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **02 - 2010 ADDTION** B. WING ______	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00) section 18.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 40 residents, staff and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, a review of documentation and interview with the Director of Maintenance (JC), revealed the facility failed to provide documentation for 3 out of the last 4 quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Director of Maintenance (JC)	K 062	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. As of 8/28/2013, the Director of Maintenance has completed the flow test according to fire and life safety code.. We have completed and will continue to complete these tests on a quarterrly basis in accordance with fire and life safety code. 2. ED or designee will preform quarterly audits for three quarters, that the tests are being done and documented correctly according to fire and life safety code. 3. 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	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 02 - 2010 ADDTION B. WING	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 Life safety Code section 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 40 residents, staff, and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, documentation review of the emergency generator testing logs indicated that the facility failed to conduct 12 weekly inspections and 3 monthly inspections of the emergency generator from December 2012 to the date of this inspection. This deficient practice was verified by the Director of Maintenance (JC)	K 144	K 144 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. As of 9/14/2013 the Director of Maintenance completed the required load test once a month according to fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the load test are being done and documented correctly according to fire and life safety code. 3. The data collected will be presented to the QA Committee by the ED. 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 amd required audits. Completion date: January 24, 2014	

F5375023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	12/19/2013

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

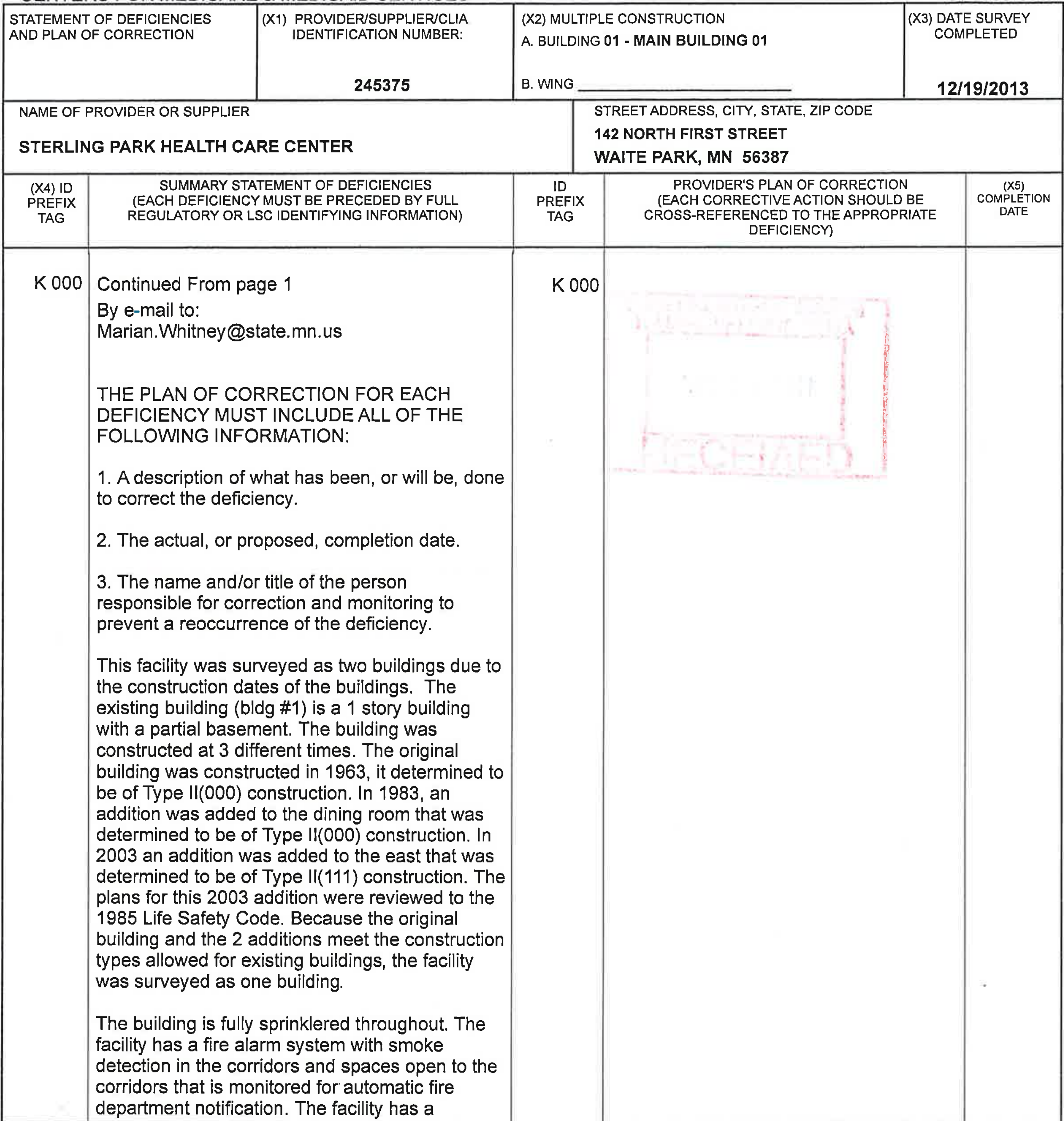
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Fire Safety: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, Sterling Park Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok w/AW for K55 TB 1-30-14 RECEIVED JAN 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	1.17.14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/19/2013

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



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us 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. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two buildings due to the construction dates of the buildings. The existing building (bldg #1) is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963, it determined to be of Type II(000) construction. In 1983, an addition was added to the dining room that was determined to be of Type II(000) construction. In 2003 an addition was added to the east that was determined to be of Type II(111) construction. The plans for this 2003 addition were reviewed to the 1985 Life Safety Code. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 licensed capacity of 60 and had a census of 40 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 050 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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. As of 8/28/2013, the Director of Maintenance has completed the drills according to fire and life safety code. We have preformed a drill on all shifts. We have completed and will continue to complete these drills on a regular basis and in accordance with fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the drills are being done and documented correctly according to fire and life safety code. 3. 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 Completion date: January 24, 2014	
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 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct 4 of 12 required fire drills as required by the NFPA 101 Life Safety Code (00) section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 40 residents, visitors and staff. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, during a documentation review of the available fire drill reports for the last 12 months and interview with the Director of Maintenance (JC), it was revealed that the facility failed to conduct 2 fire drills in the second quarter, and 2	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 3 fire drills in the 3rd quarter of the calendar year. This deficient practice was verified by the Director of Maintenance (JC)	K 050	K 052 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting all 40 residents, staff, and visitors of the facility. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, during a documentation review of the	K 052	1. As of 8/28/2013, the Director of Maintenance has completed the drills according to fire and life safety code. We have preformed a drill on all shifts. We have completed and will continue to complete these drills on a regular basis and in accordance with fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the drills are being done and documented correctly according to fire and life safety code. 3. 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 Completion date: January 24, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	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)	K 052		
K 055 SS=D	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. Findings Include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, it was observed that resident room ~~E-17~~ E-18 does not have a window to the exterior. The reason for this deficient condition is from the exterior courtyard being enclosed during the 2010	K 055	K 055 Waiver attached	AW

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 055 E-18	Continued From page 5 addition and remodeling project. During an interview with the Director of Maintenance (JC), room ~~E-17~~ is 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)	K 055	K 062 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 40 residents, staff and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, a review of documentation and interview with the Director of Maintenance (JC), revealed the facility failed to provide documentation for 3 out of the last 4 quarterly fire sprinkler flow tests inspections required by NFPA	K 062	1. As of 8/28/2013, the Director of Maintenance has completed the flow test according to fire and life safety code.. We have completed and will continue to complete these tests on a quarterly basis in accordance with fire and life safety code. 2. ED or designee will preform quarterly audits for three quarters, that the tests are being done and documented correctly according to fire and life safety code. 3. 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	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/19/2013**

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

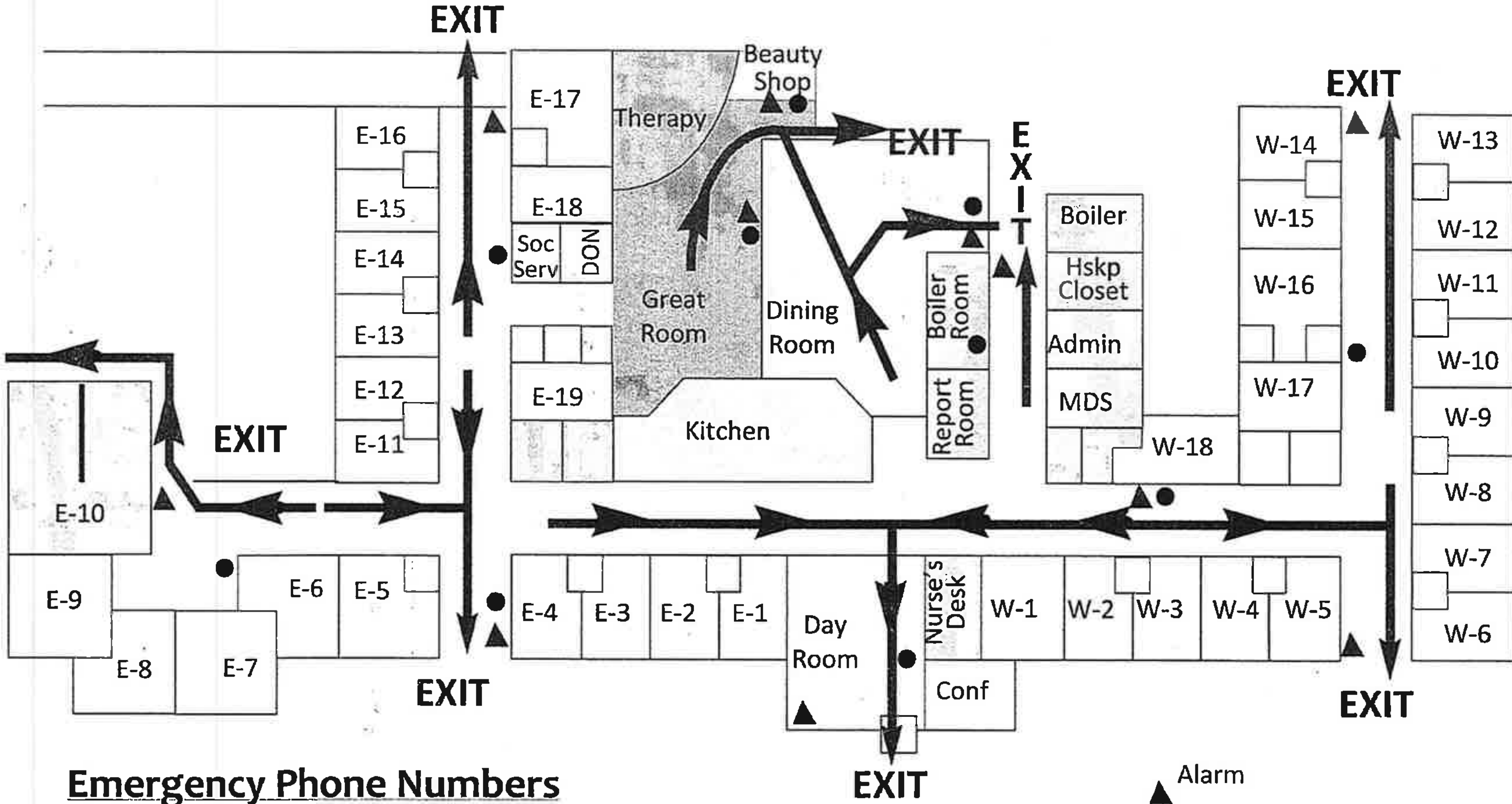
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 6 13(99) and NFPA 25(98). This deficient practice was verified by the Director of Maintenance (JC)	K 062	Completion date: January 24, 2014	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 40 residents, staff, and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 12/19/2013, documentation review of the emergency generator testing logs indicated that the facility failed to conduct 12 weekly inspections and 3 monthly inspections of the emergency generator from December 2012 to the date of this inspection.	K 144	K 144 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **01 - MAIN BUILDING 01** B. WING	12/19/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 7 This deficient practice was verified by the Director of Maintenance (JC)	K 144	1. As of 9/14/2013 the Director of Maintenance completed the required load test once a month according to fire and life safety code. 2. ED or designee will preform monthly audits for three months, that the load test are being done and documented correctly according to fire and life safety code. 3. The data collected will be presented to the QA Committee by the ED. 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 amd required audits. Completion date: January 24, 2014	

Sterling Park Health Care Center
Fire Evacuation Plan



Emergency Phone Numbers

Fire Dept.	911
Police Dept.	911
Director of Maintenance	320-309-7011
Maintenance	320-282-2870
Administrator	218-343-2117