DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			AND TRANSMITTAL ID: 94KU		
PAR	T I - TO BE COMPL	LETED BY TH	IE STATI	E SURVEY AGENCY	Facility ID: 00643
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245375 	3. NAME AND ADDR (L3) STERLING PA			TFR	4. TYPE OF ACTION: <u>7 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.	(L4) 142 NORTH FI				1. Initial 2. Recertification
(L2) 502490100	(L5) WAITE PARK,			(L6) 56387	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Site Visite 0. Other
 EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 	7. PROVIDER/SUPPL 01 Hospital	LIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/20/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS	CERTIFIED AS:			·
From (a):	X A. In Compliance	With		And/Or Approved Waivers Of The	Following Requirements:
To (b):	Program Requir Compliance Ba			2. Technical Personnel	6. Scope of Services Limit
				3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 53 (L18)	1. Acce	eptable POC		4. 7-Day RN (Rural SNF)	—
13.Total Certified Beds 53 (L17)	B. Not in Complia	ance with Program		5. Life Safety Code	9. Beds/Room
	Requirements and	/or Applied Waiver	rs:	* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
53					
(L37) (L38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE	SHOW LTC CANCELLAT	TION DATE):			
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Mardelle Trettel, HFE NE II	01/	/20/2016	(L19)	Kate JohnsTon, Pr	rogram Specialist 02/03/2016 (L20)
PART II - TO	BE COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	
19. DETERMINATION OF ELIGIBILITY	20. COMPL	IANCE WITH CI	VIL	21. 1. Statement of Financi	
_X 1. Facility is Eligible to Participate	RIGHTS	S ACT:		 Ownership/Control I Both of the Above : 	interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible					
(L21)					
22. ORIGINAL DATE 23. LTC AGREEM	IENT 24.	LTC AGREEMEN	TI	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING	DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY
12/01/1986				01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNATIV	'E SANCTIONS			03-Risk of Involuntary Termination	OTHER
A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27) D. Bergoird Su		(L44)			00-Active
B. Rescind Su:	spension Date:				
		(L45)		20. 05.14.020	
28. TERMINATION DATE: 29	9. INTERMEDIARY/CAR	KIEK NO.		30. REMARKS	
	03001				
(L28)			(L31)		
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF	APPROVAL DATE	E	Posted 02/16/2016 Co.	
(L32)	12/31/2015		(L33)	DETERMINATION APPRO	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245375 February 3, 2016

Ms. Heather Potter, Administrator Sterling Park Health Care Center 142 North First Street Waite Park, Minnesota 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 1, 2016 the above facility is certified for or recommended for:

53 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sterling Park Health Care Center February 3, 2016 Page 2

Sincerely,

Katot moton

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

cc: Licensing and Certification File



Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0565 January 20, 2016

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

RE: Project Number S5375026

Dear Ms. Potter:

On November 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 2, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on November 13, 2015.

However, compliance with the health deficiencies issued pursuant to the November 13, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 13, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 13, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 13, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Sterling Park Health Care Center January 20, 2016 Page 2

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Sterling Park Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 13, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE

Sterling Park Health Care Center January 20, 2016 Page 3 SURVEY

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 May 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

January 28, 2016

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

RE: Project Number S5375026

Dear Ms. Potter:

On January 20, 2016, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 13, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of January 20, 2016, 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 February 13, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on November 13, 2015, and lack of verification of substantial compliance with the health deficiencies at the time of our January 20, 2016 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 13, 2015, as of January 1, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of January 20, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Sterling Park Health Care Center January 28, 2016 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 13, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 13, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 13, 2016, is to be rescinded.

In our letter of January 20, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 13, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 1, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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,

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

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building		4/20/2040	
245375 _{Y1}	B. Wing	Y2	1/20/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER		142 NORTH FIRST STREET		
		WAITE PARK, MN 56387		

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

ITE	м	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	F0241 483.15(a)	Correction Completed 12/23/2015	ID Prefix F0282 Reg. #	2 D(k)(3)(ii)	Correction Completed	ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 12/23/2015
ID Prefix	F0314	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.25(c)	Completed	Reg. #		Completed	Reg. #			Completed
LSC		12/23/2015	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC						LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. # LSC		Completed	Reg. # LSC			Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS) BF/KJ	DATE	SIGNATURE OF SU		007		DATE	20/2016
REVIEWE CMS RO	D BY	BF/KJ REVIEWED BY (INITIALS)	01/28/2016 Date	TITLE	349	18/		DATE	20/2016
FOLLOW	JP TO SURVEY CO	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				в 🗌 NO		

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT	
245375 _{Y1}	B. Wing	Y2	1/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER		142 NORTH FIRST STREET		
		WAITE PARK, MN 56387		

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

ITE	ITEM DATE		ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0018	Correction Completed 12/23/2015	ID Prefix Reg. # LSC K0029	01 Correction 01 Completed 11/17/2015	Reg. #	Correction FPA 101 Completed 0062 01/01/2016
ID Prefix Reg. # LSC	NFPA 101 K0070	Correction Completed 12/23/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. #	Correction	ID Prefix Reg. #	Correction
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
REVIEWE STATE AG REVIEWE CMS RO FOLLOWU 11/10/201	BENCY	REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR 347 TITLE ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN	5. WAS A SUMMA	



Protecting, Maintaining and Improving the Health of Minnesotans

January 28, 2016

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

Re: Enclosed Reinspection Results - Project Number S5375026

Dear Ms. Potter:

On January 20, 2016 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 November 13, 2015, with orders received by you on December 3, 2015. 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,

Inston

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT		
IDENTIFICATION NUMBER	A. Building				
00643 _{Y1}	B. Wing	Y2	1/20/2016	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
STERLING PARK HEALTH CARE CENTER		142 NORTH FIRST STREET			
		WAITE PARK, MN 56387			

This report is completed by a 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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4		Y5	
ID Prefix	20302	Correction	ID Prefix 20565	5	Correction	ID Prefix	20830	Correction	
Reg. #	MN State Statute 144.6503	Completed	MN Ru Reg. # Subp.	ıle 4658.0405 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1) Completed	
LSC		12/23/2015	LSC		12/23/2015	LSC		12/23/2015	
ID Prefix	20900	Correction	ID Prefix 21665	j	Correction	ID Prefix	21805	Correction	
Reg. #	MN Rule 4658.05 Subp. 3	25 Completed	Reg. #	ıle 4658.1400	Completed	Reg. #	MN St. Statute 144. Subd. 5	651 Completed	
LSC		12/23/2015	LSC		12/23/2015	LSC		12/23/2015	
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed	
LSC			LSC			LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU		07		DATE	
REVIEWED BY CMS RO REVIEWED BY (INITIALS)		REVIEWED BY	01/28/2016 date	34987 TITLE				01/20/2016 Date	
FOLLOW	JP TO SURVEY CO	DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICAID CE 7 I - TO BE COMPLETE			ID: 94KU Facility ID: 00643	
1. MEDICARE/MEDICAID PROVIDER N (L1) 245375 2.STATE VENDOR OR MEDICAID NO. (L2) 502490100	(L1) 245375 (L3) STERLI 2.STATE VENDOR OR MEDICAID NO. (L4) 142 NOF (L2) 502490100 (L5) WAITE			AME AND ADDRESS OF FACILITY STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET WAITE PARK, MN (L6) 56387		
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUPPLIER C 01 Hospital 05 HI		<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 11/13 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 06 PR 03 SNF/NF/Distinct 07 X- 04 SNF 08 OI		14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
 LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 	53 (L18) 53 (L17)	 10.THE FACILITY IS CERTI A. In Compliance With Program Requiremen Compliance Based O 1. Acceptable X B. Not in Compliance with Requirements and/or 	nts)n: e POC rith Program	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director	
18 SNF 18/19 SNF 53 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : Mary Rogers, HPR Social Work Specialist 12/30/2015 (L19)				PPROVAL Date: Cogram Specialist 12/31/2015 (L20)	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible	<i>č</i>	20. COMPLIANC RIGHTS ACT	CE WITH CIVIL	21. 1. Statement of Finance	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 24. LTC A	AGREEMENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 12/01/1986	BEGINNING	DATE END	DING DATE	VOLUNTARY 00 01-Merger, Closure 0	05-Fail to Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions: (L	.44)	02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	nt 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
		(L	.45)			
28. TERMINATION DATE:	29	INTERMEDIARY/CARRIER	NO.	30. REMARKS		
	(L28)	03001	(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION OF APPR	OVAL DATE	Posted 12/31/2015 Co.		
	(L32)		(L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0428

November 25, 2015

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

RE: Project Number S5375026

Dear Ms. Potter:

On November 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

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 3333 West Division, #212 St. Cloud, Minnesota 56301 <u>Brenda.Fischer@state.mn.us</u> Telephone: (320) 223-7338 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 23, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 23, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 13, 2016 (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 May 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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

Sterling Park Health Care Center November 25, 2015 Page 5

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



Addendum to Plan of Correction

F 241

1) R7 was evaluated and assessed by therapy for use of toileting sling. After physical therapy evaluated and treated resident, determined that she was appropriate and safe to utilize the toileting sling for assistance to the toilet. Therapy did further assess resident for safe use during late afternoon as resident identified to have increased upper body fatigue. Therapy felt that with utilizing the toileting sling only for toileting purposes that resident is appropriate. Staff will toilet resident per her choice, resident has refused to utilize toilet, in which staff offer the bed pan. Staff will continue to monitor upper extremity strength and perform exercises with resident per therapy program to assist in maintaining strength. Resident has expressed satisfaction with current toileting plan.

F 282

5) DNS or designee will perform pressure ulcer audit twice weekly for one month and once weekly for two months. Audit will include review of resident's medical record as well as observing for staff following care plan accordingly to ensure interventions for impaired skin are followed. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, intervention and ongoing audits.

F 314

4) DNS or designee will complete two turn and reposition audits weekly for one month and once weekly for two months. Audit will evaluate for correct turning and repositioning of residents according to their care plan. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, intervention and ongoing audits.

Heather Potter 12.30.15

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

Commons (Assisted Living) 35 1st Avenue N. Waite Park, MN 56387 320-252-7224 Fax: 320-252-5629 Park Gardens (Independent Living) 114 N. 1st Street Waite Park, MN 56387 320-252-7224 Fax: 320-252-5629

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	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.					
F 241	revisit of your facilit that substantial cor has been attained i verification.	acceptable POC an on-site acceptable POC an on-site accordance with the regulations n accordance with your AND RESPECT OF	F 2	241		~	
SS=D	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on interview facility failed to pro- residents (R7) who having to use a bed Findings include: R7's quarterly Minu 6/18/15, identified f	imum Data Set (MDS) dated R7 had intact cognition, assistance with toileting, and	2 201	- And	F 241 The preparation of the following of correction for this deficiency not constitute and should not b interpreted as an admission no agreement by the facility of the of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of corre prepared for this deficiency was executed solely because provis of state and federal law require Without waiving the foregoing	does e r an truth ons ction s sions	
	an, "ADL [activities Performance Defic	ed 9/30/15, identified R7 had of daily living] Self Care it", and for toileting R7	pr a	Nº K	statement, the facility states wir respect to:	h	
LABORATOR'	Y DIRECTOR'S OP-PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG		ι	TITLE		(X6) DATE
L.C.	Har boll	Exp	· th	~ N	urector 17	. 15-1	5

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 241	hygiene/clothing/pro- able to sit on toilet/ already in bed]." During an interview stated she used to the toilet/commode getting assistance v since, "They [staff] R7 stated she now to void, and she did "I like to do my buis the bathroom." R7 facility had offered R7's PT (physical to dated 10/21/15, ide completed of R7's toilet/commode afte the mechanical lift able to use the toile or toilet. R7's progress note "Voiced frustration toilet any longer an briefs." A subsequ identified R7, "Voic use the bedpan [sid is too difficult to try Writer reminded he her to use the bedp notes identified the on 10/21/15 in whic the toilet sling and	ist to transfer and related oduct management. She is commode and bedpan [if receive help from staff to use , however had not been with using a commode or toilet dropped my out of the sling." was required to use a bed pan d not like it, "I hate it," adding, sness [void and defecate] in was unable to rmember if alternative toileting options. herapy) - Hospice Evaluation entified an evaluation was ability to transfer to the er she sustained a fall out of sling. R7 was assessed to be et sling and use the commode dated 10/22/15, identified R7, that she could not use the d had to use a bed pan or her ent note dated 10/24/15, ed complaints about having to c] throughout the day. States it and poop in the bedpan. er that it is safer at this time for ban" None of the progress therapy screening completed ch R7 was deemed safe to use transfer to the toilet.		241	 R7 continues to be evaluated by therapy f safety with use of toile sling related to upper extremity weakness ar ability to maintain self sling. R7 interviewed a continues to state she not want to utilize ham toileting sling in order f utilize toilet or commod Resident only wishes f utilize toileting sling if a to do so safely. All residents receive a comprehensive transfe repositioning assessm upon admission, quart and with a significant change. All staff will receive reeducation by Decem 23, 2015 regarding res dignity and choice. DNS or designee will conduct audits twice w for one month and the once weekly for two m on dignity and choice. data collected will be reviewed/discussed at monthly QA meeting. this time the QA comm will make the decision/recommenda regarding any follow-u studies and required a 	ing d n the nd does mock o ie. o able r and ent erty ber ident ber ident the At ittee ion o		
		v on 11/12/15, at 1:15 p.m. NA)-A stated R7 had voiced			6. Completion date 12-23	-15		

Facility ID: 00643

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Facility ID: 00643

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 282	Continued From pa accordance with ea care. This REQUIREMEN by: Based on observar review, the facility fi interventions for 1 of for pressure ulcers Findings include: R4's quarterly Minin 10/19/15, indicated impaired and requi toileting, transfers, four pressure ulcer R4's plan of care d was incontinent of moisture associate stage four pressure The care plan direct hour for incontinen side every hour wh During a continuou from 1:00 p.m. to 2 lying on her back ir under her left flank unchanged for one minutes. During an interview NA-C stated she d had been repositio "did not pass that a should be repositio	NT is not met as a tion, interview and ailed to implemen of 3 residents (R4) mum Data Set (M she was severely red extensive assi bed mobility and f on her coccyx. ated 10/29/15 indi bowel and bladde d skin damage ald e ulcer to sacral/co cted staff to check ce and reposition ile in bed. s observation on s coservation on hour and twenty s o on 11/12/15 at 2: id not know the las ned. NA-C stated, along." NA-C furth	evidenced document t care plan reviewed DS) dated cognitively stance with had a stage cated she r and had ong with a occyx area. R4 every her side to 11/12/15 observed billow tucked nained seven 29 p.m., st time R4 the last shift	F2	282	of correct not con interpre- agreem of the fa set forth deficien prepare execute of state Without	eparation of the following ection for this deficiency stitute and should not b beted as an admission no nent by the facility of the acts alleged or conclusion in the statement of ncies. The plan of corre ed for this deficiency wa ed solely because provise and federal law requires twaiving the foregoing ent, the facility states with to: Resident R4 had an updated comprehensive skin and positioning evaluation completed of December 7th, 2015. F also had care plan revi and revised to reflect current care.	does e r an truth ons ction s sions it. th e e an A e ewed skin iewed	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Facility ID: 00643

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F 309	10/19/15, identified impairment, and ha on her coccyx. R4' indicated R4 had lin acute pain in press rheumatoid arthritis plan indicated, R4 I dressing changes t denies pain when a moaning, grimacing plan identified R4's out of "10" and dire for pain relief. A care area assess R4 had a "history o further indicated the past 5 days, howev well as staff intervie some pain indicato during dressing cha indicated R4's over as possible." During a dressing of 11/12/15, at 7:38 a. that hurts", while F change to her cocc non-verbal signs of dressing change w that during the wee typically have disco RN-A stated that R pain medication pri On 11/12/15 at 8:2-	num Data Set (MDS) dated R4 had severe cognitive d a stage four pressure ulcer s care plan dated 10/29/15 nited physical mobility and ure ulcer as well as and osteoporosis. The care has acute pain related to o coccyx, but will immediately taked. She does display some g, and says, "Ow!" The care acceptable level of pain as "0" cted staff to anticipate need ment dated 10/15/15 indicated f back pain." The care plan at R4, denied all pain in the rer, personal observation as aws, identify that R4 displays rs and complains of pain anges. The assessment fall goal is "to be as pain free change observation on .m., R4 stated "ouch, ouch, N-A performed a dressing by R4 had not other discomfort. When the as completed, RN-A stated why wound rounds, R4 "doesn't omfort with dressing changes." 4 did not have and scheduled or to coccyx dressing change. 4 a.m., RN-A and human	F 3	1. R Proto bo 10 2. A C a a 3. A 7 4. I 4. I	4 had a Comprehensive ain evaluation completed in 12-15-14. Care Plan has een reviewed and revised oreflect current care eeds. Il residents receive a Comprehensive Pain assessment upon admission, quarterly, with a significant change. Pain is nonitored daily with care and pre and post pain medication administration. All nursing staff will receiv re-education regarding pa management by 12-23-15 DNS or designee will complete audits twice a week for a month and ond a week for a month and ond a week for two months. T data collected will be reviewed/discussed at the monthly QA meeting. At this time the QA committe will make the decision/recommendation regarding any follow-up studies and required aud DNS responsible Completion date 12-23-1	a e in · be e a its.	
FORM CMS-2	567 (02-99) Previous Versions	r (HRM) entered R4's room to S Obsolete Event ID:94KU1	L 1	Facility ID: 00643	If continua	ation sheet	Page 6 of 11

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING			11/	13/2015
	PROVIDER OR SUPPLIER	RE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387	1 117	15/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	perform morning ca observed changing registered nurse (R bottom, R4 stated, like that at all." Duri at 8:40 a.m., nursin routinely performs F has discomfort with bottom. During and interview licensed practical n complains of discor care, and movemer only Tylenol for pair not receiving any so LPN-A further state Tylenol two times di 2015. A review of Sterling [Center] Progress N indicated four sepai had pain noted. Pa with dressing chang pain on 11/11/15. O pressure ulcer was discomfort with care noted to have disco A review of R4's me indicated R4 had re during September 2 offered) and Novem even though staff st discomfort with drest	Ares. RN-A and HRM were R4's incontinent product. As N)-A was washing R4's "Ow, I don't like that, I don't ng an interview on 11/13/15, g assistant (NA)-B (who R4's morning cares), stated R4 cares, especially with her w on 11/13/15, at 8:40 a.m., urse (LPN)-A stated, R4 nfort with transfers, wound nt. LPN-A stated R4 received n relief as needed, and was cheduled pain medications. d, R4 had only received uring the month of November Park Health Care CTR lotes dated 10/23/15- 11/11/15 rate days in which resident in was described as "pain ge" on 11/12/15, "bad" back n 10/29/15, the coccyx described as having es and on 10/23/15, R4 was imfort with cares. edication administration record ceived no pain medication 2015, October 2015 (3 doses nber 2015 (3 doses offered), tated R4 had pain and ssing changes and cares. R4's	FS	:09			
	review of these thre	pain free as possible." In the months documentation for the RN weekly assessment, the					

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Facility ID: 00643

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTE

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED	
		245375	B. WING			11/13/2015		
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			STREET ADDRESS, CITY, STATE, ZIP CODE			
STERLIN	IG PARK HEALTH CA	RECENTER			142 NORTH FIRST STREET NAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)			BE	(X5) COMPLETION DATE	
F 309	days (pain scale ra pain and 10 being s days at a level 2.0 a further review of the no evidence that st pain. during the rev dressing changes, R4's reported pain received a dressing days. Most of the d rated her pain. On 11/13/15, at 8:4 contacted R4's prin discomfort noted d 11/12/15 at approx received a subsequ dressing changes. During an interview director of nursing any consistent com ask R4 about pain and was a reliable stated if R4 was ha assistants would nu	age 7 I R4's pain was a 4.0 on 2 ting of 0-10 with 0 being no severe pain); there were 9 and one day being 0. In e medication record, there was aff asked or observed R4 for view of the every three day the nursing staff documented as "0", even though R4 g change to her coccyx every 3 lays, it did not identify what R4 44 a.m., RN-A stated that she nary physician about the uring dressing change on imately 9:49 a.m., and uent order for Tylenol prior to v on 11/13/15, at 8:52 a.m., the (DON) stated, R4 has not had hplaints of pain and that staff during her dressing changes reporter. The DON further aving pain, the nursing otify the nurse who would ask	F3	309				

Although R4's care plan and assessments indicated she had discomfort related to dressing changes, with movement, and with cares. There was no indication the facility completed a comprehensive pain assessment to determine what interventions could be implemented to reduce R4's discomfort before pressure ulcer

Facility ID: 00643

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R4 about her pain level. She stated she would expect the nurses to follow through with what is care planned.

dressing change, during transfers and with

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Event ID:94KU11

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		A MEDIOAD SERVICES	·····			<u>MB NO.</u>	0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		E CONSTRUCTION		E SURVEY IPLETED
		245375	B. WING			11/	13/2015
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET IAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 314 SS=D	Continued From pa personal cares. A facility policy labe 2015 indicated its p for consistent asses documentation of p maximum comfort a The policies guideli limited to: Recogniz treat pain before pa prevent or minimize procedures, cares a 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat review, the facility fa repositioning for 1 of for pressure ulcers.	ge 8 led Pain Management, dated urpose: to provide guidelines ssment, management and ain in order to provide and enhanced quality of life. nes included but were not the and report pain, intervene to in becomes severe and to the anticipated pain (during and treatments) ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and the healing, prevent infection and from developing.		309		plan does an truth ns tion	
		num Data Set (MDS) dated R4 had severe cognitive			Without waiving the foregoing statement, the facility states with respect to:		,

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Event ID:94KU11

Facility ID: 00643

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	OMB NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245375	B. WING			11/	13/2015
NAME OF	PROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STERLIN	IG PARK HEALTH CA	RECENTER		· ·	42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 314	activities of daily liv pressure ulcer (tota muscle and bone), "Turning/reposition R4's Pressure Ulce (CAA) dated 7/16/1 existing pressure u schedule of turning Braden assessmen to be at moderate r development. R4's care plan date "Potential for press directed staff to, "R Hourly side to side activities and dialys During observation 7:36 a.m. registered dressing on R4's co stage IV pressure u with extensive dest damage to muscle, structures) was me (centimeters) by 0.3 base of bright red g immediately surrou bright red in colored (white coloration). During continuous 1:00 p.m. to 2:27 p on her back, with a side. She remaine repositioned or offer	ed extensive assistance with ing (ADLs), had a stage IV Il loss of skin extending into and was on a, program." r Care Area Assessment 5, identified R4 had an lcer, and required a regular and repositioning. R4's it dated 10/15/15, identified R4 isk of pressure ulcer	F S	314	 R4 had a comprehensive skin and positioning evaluation completed on December 7th, 2015 and care plan reviewed and revised to reflect current cares. All residents receive a comprehensive skin assessment on admission, quarterly and with a significant change. Skin conditions observed daily with cares. IDT performs review of all alterations in skin. All nursing staff will receive re-education by December 23, 2015 regarding plan of care. DNS or designee will complete two audits weekly for one month, and then on audit weekly for two months. 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 DNS is responsible Completion date 12-23-15 	/ e	

Facility ID: 00643

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		A MEDICAID SERVICES			ON	1B NO. 0938-039
STATEMEN AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	-	X3) DATE SURVEY COMPLETED
		245375	B. WING			11/13/2015
	PROVIDER OR SUPPLIER	RECENTER		STREET ADDRESS, CITY, ST. 142 NORTH FIRST STREE WAITE PARK, MN 5638	Т	11/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION /E ACTION SHOULD E D TO THE APPROPRI CIENCY)	(X5) BE COMPLETIO ATE DATE
F 314	had a stage IV pres When interviewed a 11/12/15, at 2:29 p. stated she was una repositioned adding that [information] al R4 should be repose bed as care planne time. During interview on stated R4 should be when in bed. When interviewed of director of nursing (been repositioned e and added the nurs NA staff to make su A facility Pressure L October 2015, ident the prevention of all promote healing of prevent further loss policy directed staff approaches (i.e. rep	ssure ulcer on her coccyx. about repositioning for R4 on m. nursing assistant (NA)-C ware when R4 was last g the prior shift, "Did not pass ong." Further, NA-C stated bitioned every hour when in d. Staff repositioned R4 at that 11/12/15, at 2:33 p.m. RN-A e repositioned every hour on 11/12/15, at 2:47 p.m. the DON) stated R4 should have every one hour when in bed, es were expected to help the ire R4 was repositioned timely. Jlcer Prevention policy dated tified a purpose of, "Promote teration in skin integrity; current skin alterations and to of skin integrity." Further, the to develop care plan positioning) to reduce or a risk factors and promote ulcers.				
2, 0110/20	(Obsolete Event ID:94KU11		Facility ID: 00643	It continuation	n sheet Page 11 of

PRINTED: 11/25/2015 FORM APPROVED

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	F53	375025	FORM): 11/25/2015 1 APPROVED 1. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	PLE CONSTRUCTION 6 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245375	B. WING		11/	/10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 000		1	
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CMS	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		200 0K		
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CON REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.		N		
	Minnesota Departm Fire Marshal Divisio the time of this surve Park Healthcare Cer substantial compliar participation in Medi Subpart 483.70(a), I 2000 edition of Natio Association (NFPA)	Survey was conducted by the ent of Public Safety, State n, on November 10, 2015. At ey, Building 01 of Sterling nter was found not in nce with the requirements for care/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care		RECEIVED]	
	PLEASE RETURN 1 CORRECTION FOR DEFICIENCIES (K-TAGS) TO:	THE FIRE SAFETY	×	DEC 2.9 MIN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
	Health Care Fire Ins State Fire Marshal D 445 Minnesota St., S	ivision Suite 145				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN,	-	utile Director	DINEY VS	(X6) DATE 4. 15
my deficiency ther safeguar	statement ending with an ds provide sufficient prote	n asterisk (*) denotes a deficiency whic ection to the patients. (See instructions	h the institut	on may be excused from correcting providin nursing homes, the findings stated above a	g it is deter re disclosal	mined that

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.

Contraction of the local distribution of the

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		IB NO. 0938- X3) DATE SURVE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG 01 - MAIN BUILDING 01	ľ	COMPLETED	>
		245375	B. WING			11/10/201	5
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		-
STERLIN	IG PARK HEALTH CA	ARE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5	.5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIA		ÉTIO TE
K 000			KOC	0			
	St Paul, MN 55101	-5145, or					
	By email to:						
	Marian.Whitney@s <mailto:marian.wh< td=""><td>tate.mn.us itney@state.mn.us> and</td><td></td><td></td><td></td><td></td><td></td></mailto:marian.wh<>	tate.mn.us itney@state.mn.us> and					
	Angela.Kappenmar	n@state.mn.us					
	<mailto:angela.kap< td=""><td>openman@state.mn.us></td><td></td><td></td><td></td><td></td><td></td></mailto:angela.kap<>	openman@state.mn.us>					
	THE PLAN OF CO	RRECTION FOR EACH					
	DEFICIENCY MUS FOLLOWING INFO	T INCLUDE ALL OF THE					
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.	,				
	3. The name and/or	title of the person					
	prevent a reoccurre	ection and monitoring to nce of the deficiency					
	Building 01 of Sterlin was constructed as	ng Park Healthcare Center					
	The original building	was built in 1963, is					
	one-story in height, fully fire sprinkler pr	has a partial basement, is otected, and was determined		3		í.	
1	to be of Type II(000)	construction;		3			
0	has a partial basem	ddition is one-story in height, ent, is fully fire sprinkler					
11	protected, and was (II(000) construction	determined to be of Type					
.,	The 2003 building a	ddition is one-story in height,					
	has no basement, is	fully fire sprinkler protected, to be of Type II(111)					
Ċ	construction						
	The facility has a fire	alarm system with smoke dors and spaces open to the				ę.	
		uors and spaces open to the					

and the second

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		FO	ED: 11/25/20 RM APPROVE NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) 01 - MAIN BUILDING 01	DATE SURVEY
		245375	B. WING		11/10/2015
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1/10/2010
STERLI	NG PARK HEALTH CA	RE CENTER		42 NORTH FIRST STREET	
			N	VAITE PARK, MN 56387	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
	corridors which is m department notificat licensed capacity of 37 at time of the sur- The requirement at NOT MET as evider NFPA 101 LIFE SAR Doors protecting co- required enclosures hazardous areas are those constructed or wood, or capable of minutes. Doors in s required to resist the no impediment to th are provided with a to the door closed. Du are permitted. 19. Roller latches are pr in all health care fact	 a construction of the facility has a 53 beds and had a census of 53 beds and had a census of 53 beds and had a census of 54 beds and had a census of 55 beds and had a census of 55 beds and had a census of 56 beds and had a census of 57 beds and 57 beds and	K 000	K 018 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 doors in question (E-11, E- 14, E-18, W-12, W-14) have been made to positively latch by the Facility Maintenance Director (FMD) in order to meet Life Safety Code (LSC) requirements. Completed as of: 11/12/2015	

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Event ID:94KU21

Facility ID: 00643

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STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	. 0938-039 TE SURVEY MPLETED
			(2)	UT - MAIN BUILDING 01		
	PROVIDER OR SUPPLIER	245375	B. WING		11/	/10/2015
	NG PARK HEALTH CA	RECENTER	1.	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET VAITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
	were allowed to enti- making it untenable Findings include: On facility tour betw 11/10/2015, it was of 1. The corridor door E-18, W-12, W-14 with its frame. This deficient condir Director of Maintena NFPA 101 LIFE SAN One hour fire rated fire-rated doors) or a extinguishing system and/or 19.3.5.4 prot the approved automo option is used, the a other spaces by sma doors. Doors are see field-applied protect 48 inches from the b permitted. 19.3.2. This STANDARD is Based on observation revealed that the face proper protection for areas located throug	eer the exit access corridors eeen 08:30 AM to 11:30 AM on observed that: r for resident room E-11, E-14, would not positively latch into tion was verified by the ance (MF). FETY CODE STANDARD construction (with ¾ hour an approved automatic fire n in accordance with 8.4.1 ects hazardous areas. When natic fire extinguishing system treas are separated from oke resisting partitions and elf-closing and non-rated or twe plates that do not exceed bottom of the door are 1 not met as evidenced by: ons and staff interview, it was illity has failed to provide 2 of several hazardous	K 018	 2. All staff will be educated to notify FMD when doors are not positively latching. Education will be completed by 12/23/2015 3. FMD will verify all doors positively latch at least monthly with fire drills. K 029 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 deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect 		

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Facility ID: 00643

If continuation sheet Page 4 of 7

CENTERS FOR MEDICAF STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/10/2015	
		245375	B. WING			
	PROVIDER OR SUPPLIER	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
K 062 SS≂F	areas making them negatively affect the residents, staff and Findings include: On facility tour betw 11/10/2015, observa following deficient or rooms throughout th 1. Resident room W storage room and an closing doors. This deficient condit Director of Maintena NFPA 101 LIFE SAF Required automatic continuously maintai condition and are ins periodically. 19.7.6 9.7.5 This STANDARD is Based on observatio facility failed to maint in accordance with th NFPA 101, Sections 1998 NFPA 25, section	he effected corridors and untenable, which could e exiting capabilities for visitors. een 08:30 AM to 11:30 AMon ation revealed, that the onditions hazardous storage he facility: /-1 was converted into a re not equipped with self ion was verified by the ince (MF). ETY CODE STANDARD sprinkler systems are ned in reliable operating	K 029	 The FMD has installed a self closing door closure on room W-1 to make it self closing and latching as required by the LSC for storage rooms. Completed as of: 11/17/2015 FMD will ensure self closure remains on door to W-1 as long as room is being used for storage 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 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 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	AS FOR MEDICARE	0	MB NO.	0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245375	B. WING			11/10/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER					TH FIRST STREET PARK, MN 56387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
K 062	Continued From page 5 Findings include: On facility tour between 08:30 AM and 11:30 AM on 11/10/2015, observation revealed that the following were found: 1. The kitchen, dish washing area has corroded sprinkler heads and area to link to assisted living. 2. There are multiple sprinkler heads that had dust and debris on them throughout the facility.		K 06	062	1. Per the FMD the non-compliant sprinkler heads have been		
K 070 SS=D					scheduled for repair or replacement by a licensed contractor to meet LSC requirements.		
					Scheduled date for services is: 12/23/2015 with		
					a completion date on or before: 1/1/2016 2. FMD will inspect	< °	
	Director of Maintena				sprinklers heads monthly to insure		
		ETY CODE STANDARD	K 0	70	compliance with LSC requirements.		* a
	all health care occup	ortable space heating devices are prohibited in I health care occupancies, except in		_	K 070		
	heating elements of 212 degrees F. (100	nd employee areas where the such devices do not exceed degrees C) 19.7.8			The preparation of the following plan of correction for this deficiency does not constitute and should not		
	Based on observati used portable space areas and failed to p portable space heat the requirements of (00), Section 19.7.8.	not met as evidenced by: on and interview, the facility heaters in non-resident care provide a policy on the use of ers in the facility that meets NFPA 101 Life Safety Code This deficient practice could nts, visitors and staff.			be interpreted as an admission nor an agreement by the facility o the truth of the facts allege or conclusions set forth in the statement of deficiencies. The plan of correction prepared for thi deficiency was executed solely because provisions of state and federal law requir it. Without waiving the foregoing statement, the		
					facility states with respect		

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Event ID: 94KU21

Facility ID: 00643 to:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245375	B. WING		11/10/2015	
	PROVIDER OR SUPPLIER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH FIRST STREET /AITE PARK, MN 56387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC	
K 070	on 11/10/2015, it was unapproved portable a sleeping resident portable heater was and visitors. At the facility could not pro policy regulating the heating devices with	veen 08:30 AM and 11:30AM as observed that there was an le space heater found next to in a resident room. This is accessible to other residents time of the inspection the ovide any documentation or a use of portable space hin the facility.	K 070	 As of 11/10/2015 the FMD has removed any and all space heaters to comply with the LSC. A NO space heaters allowed in this facility policy has been put in place. Copies of the policy will be included in the LSC binder and admission packets Completed as of: 12/15/2015 All staff will be educated on the NO space heater policy by: 12/23/2015 FMD will venify the policy is being followed monthly during sprinkler head inspections 		

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 02 - 2010 ADDTION		E SURVEY
		245375	B. WING			10/2015
	PROVIDER OR SUPPLIER	RECENTER		STREET ADDRESS, CITY, STATE, ZIP CO 142 NORTH FIRST STREET WAITE PARK, MN 56387	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	ΓS	K 00	00		
	FIRE SAFETY			1		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		2000 OK 12-29-15		
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.		10		
	Minnesota Departm Fire Marshal Divisio the time of this surv Park Healthcare Ce substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on, on October 16, 2014. At rey, Building 02 of Sterling enter was found not in nce with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 18 New Health Care		DECENT		
-	Occupancies. PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	THE PLAN OF R THE FIRE SAFETY TAGS) TO:		DEC 2 9 201		
	Health Care Fire Ins State Fire Marshal I 445 Minnesota Stre St. Paul, MN 55101	Division et, Suite 145		MN DEPT. OF PUBLIC S STATE FIRE MARSHAL D	AFETY IVISION	

Any deliciency 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.

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		. 0938-03 E SURVEY	
			A. BUILDI	NG 02 - 2010 ADDTION		COMIN CE TED	
		245375	B. WING		11/	10/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
STERLIN	IG PARK HEALTH CA	ARE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387			
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	By eMail to: Marian.Whitney@s	state.mn.us					
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH BT INCLUDE ALL OF THE DRMATION:	~				
	1. A description of to correct the defici	what has been, or will be, done iency.			(A		
	2. The actual, or pr	oposed, completion date.				97 	
	3. The name and/o responsible for com prevent a reoccurre	r title of the person rection and monitoring to ance of the deficiency.					
	consists of the 2010 addition. It is one-s basement, is fully fi	ing Park Healthcare Center 0 Courtyard Great Room story in height, has no re sprinkler protected, and be of Type II(111) construction.				0	
2	detection in the cor corridors which is n department notifica	e alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a f 53 beds and had a census of rvey.		19			
	The requirement at MET as evidenced	42 CFR Subpart 483.70(a) is by:					
			ð				
	E:						



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 3020 0001 8869 0428

November 25, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5375026

Dear Ms. Potter:

The above facility was surveyed on November 9, 2015 through November 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Sterling Park Health Care Center November 25, 2015 Page 2 and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 <u>Brenda.Fischer@state.mn.us</u> Telephone: (320) 223-7338 Fax: (320) 223-7348

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File

	ta Department of He				FORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00643	B. WING		11/1	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	<u> </u>	0/2010
STERLIN	G PARK HEALTH CA	ARE CENTER	th first s [.] Ark, mn 56			
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	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN RL When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	of this Department's provider and the foll issued. When corre sign and date on the the line marked with	S: , 12 and 13, 2015 surveyors staff visited the above owing licensing orders were ections are completed, please bottom of the first page in "Laboratory Director's or epresentative's signature."		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for M Homes.	oftware. to	

LABORATORY DIRECTO		PRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<u>FRather</u>	Fother	EXecutive	Director	12.15.15
STATE FORM		⁶⁸⁹⁹ 94KL	J11	If continuation sheet 1 of 19

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
		00643	B. WING		11/13/2015	
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STERLIN	NG PARK HEALTH C		TH FIRST S [.] ARK, MN 56			
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2 000	Continued From p	age 1	2 000			
	return the original Minnesota Departi Compliance Monit	ese orders for your records and to the address below: ment of Health, Division of oring, Licensing and am, 3333 West Division St, d, MN 56301.		The assigned tag number at far left column entitled "ID F The state statute/rule number corresponding text of the state out of compliance is listed in "Summary Statement of Def column and replaces the "To portion of the correction order column also includes the fit are in violation of the state s statement, "This Rule is not evidenced by." Following the findings are the Suggested I Correction and the Time Per Correction. PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL/ CORRECTION." THIS APPL FEDERAL DEFICIENCIES O WILL APPEAR ON EACH P/ THERE IS NO REQUIREME SUBMIT A PLAN OF CORR VIOLATIONS OF MINNESO STATUTES/RULES.	Prefix Tag." er and the ate statute/rule the ficiencies" o Comply" er. This ndings which tatute after the met as he surveyors Method of fiod For HEADING OF HICH AN OF LIES TO DNLY. THIS AGE. ENT TO ECTION FOR	
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related	lity serves persons with disorders, whether in a eral unit, the facility's direct				

STATE FORM

Minneso	ota Department of He	ealth			FURM	APPHOVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	SURVEY PLETED
		00643	B. WING		11/1	13/2015
	PROVIDER OR SUPPLIER	BE CENTER 142 NOR	DRESS, CITY, S TH FIRST ST ARK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 302	 care staff and their superviso care. (b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. 	rs must be trained in dementia ed training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;	2 302			
	by: Based on interview facility failed to prov interested family me Alzheimer's training training, how often, training provided. T all current residents families. Findings include: A review of the facili computer-based pro copyrighted 2014, ir included: managing philosophy and cond	ent is not met as evidenced and document review, the ide to residents and/or embers information regarding: g staff received, who received and a description of the 'his had the potential to affect of the facility and their ty's Alzheimer's training, a ogram from Relias Learning, idicated the course modules of challenging behaviors; a cepts in caring for people with ia; therapeutic activity				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMI	<u>esota De</u>	epartment of He	<u>ealth</u>			1 Of IIV	IAPPROVEL
MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET WAITE PARK, MN 55387 MAIL OF PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES EEXAL DEFICIENCY MUST BE PRECEDED BY FULL RECAU CORRECTIVE ACTIONS HOULD BE RECAUCTORY OR USC INSENTIFYING INFORMATION PROVIDER'S PLAN OF CORRECTION (EACH OPRICE) 2 302 Continued From page 3 programming for persons with dementia; and tips for communicating with individuals who have Alzheimer's disease. A review of facility course completion history, dated 11/12/2015, indicated facility staff from all disciplines received and were current Alzheimer's dementia training. 2 302 During review of admission forms and documents provided to resident of the facility indicated there was no information regarding Alzheimer's training. 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			E SURVEY PLETED
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PREEX TAG TEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PRETX TAG TAG TAG CEACH OPRICETIVE ACTION SHOULD BE CROSS-AREPERENCED TO THE APPROPRIATE DEFICIENCY 2 302 Continued From page 3 2 302 2 302 programming for persons with dementia; and tips for communicating with individuals who have Atzheimer's disease. A review of facility course completion hitsory, dated 11/12/2015, indicated facility staff from all disciplines received and were current Atzheimer's dementia training. 2 302 During review of admission forms and documents provided to resident of the facility indicated there was no information regarding Atzheimer's training. During an interview on 11/13/2015 at 2:15 p.m., the social worker (SW) said the facility does "not have a formal statement or email" regarding what Atzheimer's training is provided to the staff, which staff were trained and how often. The SW said the facility does not have" a formal document that is provided regarding the staff Atzheimer training. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Atzheimer's training is timely completed by both facility and contracted nursing staff, and residents and interested others are made aware that dementia care is timely completed by both facility and contracted nursing staff, who received training, its frequency of training, and a description of the training topics.	ID	SUMMARY STA			T		0/5)
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The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by both facility and contracted nursing staff; and residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics.	for c Alzh com facili curre Durin provi was Durin the s have Alzhe staff the fa famill at "re basis state docu	communicating neimer's disease npletion history, lity staff from all rent Alzheimer's ing review of ad vided to residen a no information ing an interview social worker (S e a formal state neimer's training f were trained a facility does talk ily and consume resident council' is with both resided, the facility "counce that is pro-	with individuals who have e. A review of facility course dated 11/12/2015, indicated disciplines received and were dementia training. Imission forms and document t of the facility indicated there regarding Alzheimer's training on 11/13/2015 at 2:15 p.m., SW) said the facility does "not ment or email" regarding wha is provided to the staff, which nd how often. The SW said a about dementia care "with ers at care conferences," and ' and also "on an individual dents and family." The SW does not have" a formal	5 J.			
TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	The a proce comp staff; made staff,	administrator o cess to ensure: pleted by both f f; and residents le aware that de f, who received	r designee could review its Alzheimer's training is timely acility and contracted nursing and interested others are mentia training is provided to training, the frequency of				
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	IATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00643	B. WING		11/	13/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		13/2013	
STERLIN	IG PARK HEALTH CA		TH FIRST STE ARK, MN 563				
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2 565	Continued From pa	ge 4	2 565				
2 565	MN Rule 4658.0408 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565				
	Subp. 3. Use. A comust be used by all care of the resident	omprehensive plan of care personnel involved in the					
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to implement care plan f 3 residents (R4) reviewed					
	Findings include:						
	10/19/15, indicated impaired and require	num Data Set (MDS) dated she was severely cognitively ed extensive assistance with bed mobility and had a stage on her coccyx.					
	was incontinent of b moisture associated stage four pressure The care plan direct	ted 10/29/15 indicated she owel and bladder and had skin damage along with a ulcer to sacral/coccyx area. ed staff to check R4 every e and reposition her side to e in bed.					
	from 1:00 p.m. to 2:: lying on her back in under her left flank.	observation on 11/12/15 27 p.m., R4 was observed bed. She had a pillow tucked R4's position remained nour and twenty seven					

Minnesota Department of Health

	ota Department of He	ealth			FURMAPPRO	NED
STATEMEI AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
	A	00643	B. WING		11/13/2015	j
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY	, STATE, ZIP CODE		
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	During an interview NA-C stated she di had been reposition "did not pass that a should be reposition During an interview registered nurse (R repositioned every at 1:00 p.m. She sta had laid R4 down a During an interview director of nursing (turned and reposition also stated she was down after lunch. S the nurses to be be to get R4 reposition directed by the care A facility policy rega requested, but none SUGGESTED MET The director of nurs all residents to assu treatment/services a care. The director of conduct random au ensure appropriate implemented. TIME PERIOD FOF (21) days.	 on 11/12/15 at 2:29 p.m., d not know the last time R4 ned. NA-C stated, the last shift long." NA-C further stated, R4 ned every hour. on 11/12/15, at 2:33 p.m., N)-A stated, R4 should bed hour which was last completed ated she was not sure who t that time. on 11/12/15, at 2:47 p.m., the DON) stated, R4 should be oned every hour. The DON is unsure who had laid R4 he stated she would expect helping the nursing assistants ed in a timely manner, as a plan. rding care planning was a were provided. HOD OF CORRECTION: ing or designee, could review as directed by the plan of of nursing or designee, could dits of the delivery of care; to care and services are Subp. 1 Adequate and 				
	epartment of Health		I		<u></u>]
TATE FORM	1		6899	94KU11	If continuation sheet 6	5 of 19

	ta Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00643	B. WING		11/13/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , </u>	10/2010
STERLIN	IG PARK HEALTH CA	ARECENTER	TH FIRST STR ARK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	receive nursing ca custodial care, and individual needs at the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	a general. A resident must re and treatment, personal and d supervision based on and preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review, the facility t interventions to rec	ient is not met as evidenced tion, interview and document failed to identify and implement duce discomfort for 1 of 3 ntified with discomfort.				
	R4's quarterly Mini 10/19/15, identified impairment, and ha on her coccyx. R4 indicated R4 had lin acute pain in press rheumatoid arthritis plan indicated, R4 dressing changes t denies pain when a moaning, grimacing plan identified R4's	mum Data Set (MDS) dated I R4 had severe cognitive ad a stage four pressure ulcer 's care plan dated 10/29/15 mited physical mobility and sure ulcer as well as and osteoporosis. The care has acute pain related to to coccyx, but will immediately asked. She does display some g, and says, "Ow!" The care acceptable level of pain as "0" ected staff to anticipate need				
	A care area assess	ment dated 10/15/15 indicated				

STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00643	B. WING		11/	13/2015
AME OF F	ROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TERLIN	G PARK HEALTH C		TH FIRST STR			
		WAITE P	ARK, MN 563	87		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From p	age 7	2 830	1999		
	R4 had a "history of further indicated th past 5 days, howe well as staff intervi- some pain indicated during dressing ch indicated R4's over as possible." During a dressing 11/12/15, at 7:38 at that hurts", while f change to her coord non-verbal signs of dressing change we that during the weat typically have disco RN-A stated that F pain medication pr On 11/12/15 at 8:2 resources manage perform morning c observed changing registered nurse (F bottom, R4 stated like that at all." Duri at 8:40 a.m., nursin routinely performs has discomfort with bottom.	of back pain." The care plan nat R4, denied all pain in the ver, personal observation as iews, identify that R4 displays ors and complains of pain nanges. The assessment arall goal is "to be as pain free change observation on n.m., R4 stated "ouch, ouch, RN-A performed a dressing cyx. R4 had not other f discomfort. When the vas completed, RN-A stated ekly wound rounds, R4 "doesn't omfort with dressing changes." R4 did not have and scheduled for to coccyx dressing change. ext did not have and scheduled for to coccyx dressing change. A4 a.m., RN-A and human er (HRM) entered R4's room to ares. RN-A and HRM were g R4's incontinent product. As RN)-A was washing R4's , "Ow, I don't like that, I don't ring an interview on 11/13/15, ng assistant (NA)-B (who R4's morning cares), stated R4 h cares, especially with her				
	licensed practical r complains of disco care, and moveme only Tylenol for pai not receiving any s	murse (LPN)-A stated, R4 mfort with transfers, wound ent. LPN-A stated R4 received in relief as needed, and was scheduled pain medications. ed, R4 had only received				
1	Tylopol two times	during the month of November				

Minnesota Department of Health STATE FORM

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If continuation sheet 8 of 19

PHEFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPI DAT 2 830 Continued From page 8 2 830 2 830	Minnes	Minnesota Department of Health					
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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 8 2015. 2 830			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (xe complete CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 8 2015. 2 830 2 830			00643	B. WING		11/1	3/2015
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) (xe COMPI DATE 2 830 Continued From page 8 2015. 2 830 2 830 2 830	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		-
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPI DAT 2 830 2015. 2 830	STERLI	NG PARK HEALTH CA					
2015.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
	2 830		ige 8	2 830			
A roviow of Starling Dark Llasth Care OTD		2015.					
A review of Sterling Park Health Care CTR [Center] Progress Notes dated 10/23/15-11/11/15 indicated four separate days in which resident had pain noted. Pain was described as "pain with dressing change" on 11/12/15, "bad" back pain on 11/11/15. On 10/29/15, the coccyx pressure ulcer was described as having discomfort with cares and on 10/23/15, R4 was noted to have discomfort with cares. A review of R4's medication administration record indicated R4 had received no pain medication during September 2015, October 2015 (3 doses offered) and November 2015 (3 doses offered), even though staff stated R4 had pain and discomfort with dressing changes and cares. R4's goal was to be "as pain free as possible." In review of these three months documentation for pain rating during the RN weekly assessment, the facility documented R4's pain was a 4.0 on 2 days (pain scale rating of 0-10 with 0 being no pain and 10 being severe pain); there were 9 days at a level 2.0 and one day being 0. In further review of the emclication record, there was no evidence that staff asked or observed R4 for pain. during the review of the wery three day dressing changes, the nursing staff documented R4's reported pain as "0", even though R4 received a d ressing change to her coccyx very 3 days. Most of the days, it did not identify what R4 rated her pain.		[Center] Progress N indicated four sepa had pain noted. Pa with dressing chang pain on 11/11/15. O pressure ulcer was discomfort with care noted to have disco A review of R4's me indicated R4 had re during September 2 offered) and Novem even though staff st discomfort with dres goal was to be "as p review of these thre pain rating during th facility documented days (pain scale rat pain and 10 being s days at a level 2.0 a further review of the no evidence that sta pain. during the revi dressing changes, t R4's reported pain a received a dressing days. Most of the day	Notes dated 10/23/15- 11/11/15 rate days in which resident in was described as "pain ge" on 11/12/15, "bad" back on 10/29/15, the coccyx described as having es and on 10/23/15, R4 was omfort with cares. edication administration record eceived no pain medication 2015, October 2015 (3 doses ober 2015 (3 doses offered), tated R4 had pain and ssing changes and cares. R4's pain free as possible." In the months documentation for the RN weekly assessment, the R4's pain was a 4.0 on 2 sing of 0-10 with 0 being no severe pain); there were 9 and one day being 0. In the medication record, there was aff asked or observed R4 for iew of the every three day the nursing staff documented as "0", even though R4 change to her coccyx every 3				
On 11/13/15, at 8:44 a.m., RN-A stated that she contacted R4's primary physician about the discomfort noted during dressing change on		contacted R4's prim	ary physician about the				
11/12/15 at approximately 9:49 a.m., and received a subsequent order for Tylenol prior to		11/12/15 at approxir	mately 9:49 a.m., and				
dressing changes.	/innesota D	dressing changes.	,				

Minnesc	ota Department of He	alth				AFFROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00643	B. WING		11/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1	
STERLIN	IG PARK HEALTH CA	RECENTER	H FIRST ST			
			RK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	director of nursing (any consistent com ask R4 about pain of and was a reliable of stated if R4 was ha assistants would no R4 about her pain le expect the nurses to care planned. Although R4's care indicated she had do changes, with move was no indication the comprehensive pain what interventions of reduce R4's discorn dressing change, do personal cares. A facility policy labe 2015 indicated its p for consistent assess documentation of pain maximum comfort a The policies guidelin limited to: Recogniz treat pain before pain procedures, cares a	,				
Minnesoto Da	The director of nurs all residents to assu necessary treatmen approperiate pain m	HOD OF CORRECTION: ing or designee, could review ire they are receiving the t/services to to ensure anagment is in place for all riate. The director of nursing				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	CONSTRUCTION		E SURVEY PLETED	
		00643	B. WING		11/	11/13/2015	
NAME OF PROVIDER OR SUPPLIER STREET A			DRESS, CITY, ST	ATE, ZIP CODE			
TERLIN	IG PARK HEALTH CA		TH FIRST STR ARK, MN 5638				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 10	2 830		· · · · · · · · · · · · · · · · · · ·		
	or designee, could delivery of care; to services are impler	conduct random audits of the ensure appropriate care and nented.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900				
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
•	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent veloping.					
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to complete timely of 3 residents (R4) reviewed					
	Findings include:						
	R4's quarterly Minin 10/16/15, identified	num Data Set (MDS) dated R4 had severe cognitive					

Minneso	ota Department of He	ealth				AFFNOVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	······	00643	B. WING		11/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STERLI	NG PARK HEALTH CA	KE GENTER	TH FIRST ST ARK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 11	2 900			
	activities of daily liv pressure ulcer (tota muscle and bone), "Turning/reposition R4's Pressure Ulce (CAA) dated 7/16/1	program." r Care Area Assessment 5, identified R4 had an				
	schedule of turning Braden assessmen	lcer, and required a regular and repositioning. R4's t dated 10/15/15, identified R4 isk of pressure ulcer				
	"Potential for press directed staff to, "R	d 10/29/15, identified R4 had, ure ulcer development," and eposition per individual needs: in bed, up for meals, selected is only."				
	7:36 a.m. registered dressing on R4's co stage IV pressure u with extensive destr damage to muscle, structures) was mea (centimeters) by 0.5 base of bright red g immediately surrour bright red in colored (white coloration).	of wound care on 11/12/15, at d nurse (RN)-A changed a boccyx. RN-A measured the elcer (Full thickness skin loss ruction, tissue necrosis, or bone, or supporting asured to be 4.5 cm 5 cm by 0.5 cm, with a wound ranulation tissue. The skin nding the pressure ulcer was d and appeared macerated				
Minnesota D	1:00 p.m. to 2:27 p. on her back, with a side. She remained repositioned or offer hour and twenty sev	observation on 11/12/15, from m., R4 was laying in her bed pillow tucked under her left d in this position without being red to be repositioned for one ven minutes even though R4 sure ulcer on her coccyx.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00643	B. WING		11/13/2015	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
STERLIN	NG PARK HEALTH CA	REGENIER	TH FIRST STR ARK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 12	2 900			
	11/12/15, at 2:29 p. stated she was una repositioned adding that [information] al R4 should be repos	about repositioning for R4 on m. nursing assistant (NA)-C ware when R4 was last the prior shift, "Did not pass ong." Further, NA-C stated itioned every hour when in d. Staff repositioned R4 at that				
	During interview on stated R4 should be when in bed.	11/12/15, at 2:33 p.m. RN-A e repositioned every hour				
	director of nursing (been repositioned e and added the nurs	on 11/12/15, at 2:47 p.m. the DON) stated R4 should have every one hour when in bed, es were expected to help the re R4 was repositioned timely.				
	October 2015, ident the prevention of all promote healing of prevent further loss policy directed staff approaches (i.e. rep	Jlcer Prevention policy dated tified a purpose of, "Promote teration in skin integrity; current skin alterations and to of skin integrity." Further, the to develop care plan positioning) to reduce or s risk factors and promote ulcers.				
	The director of nurs all residents at risk they are receiving th treatment/services t ulcers. The director conduct random au	HOD OF CORRECTION: ing or designee, could review for pressure ulcers to assure ne necessary o promote healing of pressure of nursing or designee, could dits of the delivery of care; to care and services are				

Minnesota Department of Health

<u>Minne</u>	sota	Depai	tment	of I	lealth	

£	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING			
		00643	B. WING		11/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA		TH FIRST ST NRK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 13	2 900			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.140	0 Physical Environment	21665			
	A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe water temperatures were maintained 10 of 15 resident rooms (W2, W12, W15, W17, E6, E10, E11, E13, E15, and E17) reviewed for environmental compliance.					
	Findings include:					-
	at approximately 2:	of resident rooms on 11/9/15, 30 p.m., the following rooms water from the faucets that not to the touch:				
	> West (W)2, W12, > East (E)6, E10, E	W15, W17; 11, E13, E15, and E17.				
	to 11/9/2015 indicat	ncident reports from 5/1/2015 ed there were no residents is or who had incidents related in the facility.				
	p.m. in the presenc maintenance assist	facility on 11/9/15, at 3:01 e of the surveyor, ant (MA)-A, measured hot from bathroom faucets in the				

Minnesota I	Department of H	ealth

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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X4) COMP		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		
THE INSTITUTE TO THE PARK, MN 56387 VAILE PARK, MN 56387 VAILE PARK, MN 56387 SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC DENTIFYING INFORMATION) 21665 Continued From page 14 21665 constrained Constrained D 21665 Continued From page 14 21665 votation V2 - 125 deg. F (degrees Fahrenheit) V12 - 122 deg. F W12 - 122 deg. F W17 - 120.2 deg. F E6 - 124.4 deg. F E10 - 126 deg. F E11 - 124 deg. F E11 - 124 deg. F E17 - 127 deg. F When interviewed on 11/9/15 at 3:25 p.m., after the facility tour, MA-A stated he was "unaware" of the established policies or procedures for maintaining resident hot water. MA-A said "the facility maintenance director" was responsible for checking the hot water temperatures. During interview on 11/9/15, at 4:10 p.m. the maintenance director (MD) stated he either used an infrared gun or a fluke thermometer to check the water temperatures.			00643	B. WING		11/13/2015	
OKALING PARK HEALTH CARE VENTER WAITE PARK, MN 56387 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION IN COMPARIANCE COMP (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PROCEDED BY FULL TAG D PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) COMP 21665 Continued From page 14 21665 21665 D DEFICIENCY) DEFICIENCY D 21665 Continued From page 14 21665 21665 D DEFICIENCY) D DEFICIENCY D D 21665 Continued From page 14 21665 D DEFICIENCY) D	NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMP DEFICIENCY) 21665 Continued From page 14 rooms listed. MA-A used a facility thermometer and the following water temperatures were observed: 21665 W2 - 125 deg. F (degrees Fahrenheit) W12 - 122 deg. F 21665 E6 - 124.4 deg. F E10 - 126 deg. F E11 - 124 deg. F E11 - 124 deg. F E13 - 121.5 deg. F E17 - 127 deg. F When interviewed on 11/9/15 at 3:25 p.m., after the facility tour, MA-A stated he was "unaware" of the established policies or procedures for maintaining resident hot water, MA-A said "the facility maintenance director" was responsible for checking the hot water temperatures. During interview on 11/9/15, at 4:10 p.m. the maintenance director (MD) stated he either used an infrared gun or a fluke thermometer to check the water temperatures.	STERLIN	IG PARK HEALTH CA	BE LENTER				
rooms listed. MA-A used a facility thermometer and the following water temperatures were observed: W2 - 125 deg. F (degrees Fahrenheit) W12 - 122 deg. F W15 - 120.2 deg. F W17 - 120.2 deg. F E6 - 124.4 deg. F E10 - 126 deg. F E11 - 124 deg. F E11 - 124 deg. F E13 - 121.5 deg. F E15 - 127.5 deg. F E17 - 127 deg. F When interviewed on 11/9/15 at 3:25 p.m., after the facility tour, MA-A stated he was "unaware" of the established policies or procedures for maintaining resident hot water, or which thermometer to test the hot water, or MA-A said "the facility maintenance director" was responsible for checking the hot water temperatures. During interview on 11/9/15, at 4:10 p.m. the maintenance director (MD) stated he either used an infrared gun or a fluke thermometer to check the water temperatures in the facility. However,	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLET DATE
was used when he recorded these water temperatures. The MD stated the hot water temperatures should be under 115 degrees, and the high readings were likely the result of a, "chunk of solder in the line that broke free," as had happened prior. Further, MD stated he did not document these occurrences, "I would have just fixed it."		rooms listed. MA-A and the following w observed: W2 - 125 deg. F (d. W12 - 122 deg. F W15 - 120.2 deg. F W17 - 120.2 deg. F E6 - 124.4 deg. F E10 - 126 deg. F E11 - 124 deg. F E13 - 121.5 deg. F E15 - 127.5 deg. F E17 - 127 deg. F When interviewed of the facility tour, MA the established poli maintaining residen thermometer to test "the facility mainten responsible for chea temperatures. During interview on maintenance directo an infrared gun or a the water temperatures the MD did not reco was used when he temperatures. The temperatures should the high readings w "chunk of solder in t had happened prior not document these	A used a facility thermometer ater temperatures were egrees Fahrenheit) egrees Fahrenheit) A stated he was "unaware" of cies or procedures for t hot water, or which t hot water, or which t hot water, or which the hot water. MA-A said ance director" was cking the hot water 11/9/15, at 4:10 p.m. the pr (MD) stated he either used fluke thermometer to check ures in the facility. However, rd which thermometer type recorded these water MD stated the hot water d be under 115 degrees, and ere likely the result of a, the line that broke free," as . Further, MD stated he did				

STATE FORM

Minneso	ota Department of He	ealth				APPHOVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00643	B. WING		11/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RECENTER	TH FIRST ST ARK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 15	21665			
	temperatures had b adding, "I [now] bel MD stated he was u were taking to redu residents in the fac the past with hot wa During an interview administrator stated a plumber to resolv past when the wate too hot, the tempera frequently, but the a provide any docume	on 11/13/15, at 12:30 p.m. the d the facility was working with e the hot water issues. In the r temperature would become atures were checked more administrator was unable to entation for it.				
21805	The facility administ review all water terr resident, staff and v potential for burns. designee, could corr water temperatures temperatures are m procedures are con TIME PERIOD FOF (21) days.	HOD OF CORRECTION: trator or designee, could aperature logs to ensure visitor safety in regard to The administrator or nduct random audits of the and logs to ensure safe water valintained and policies and sistently implemented. A CORRECTION: Twenty-one 651 Subd. 5 Patients & uc.Bill of Rights	21805			
Minnesota De	Subd. 5. Courteoursidents have the r	us treatment. Patients and right to be treated with ct for their individuality by				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00643	B. WING		11/13/2015	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TERLIN	NG PARK HEALTH CA		TH FIRST STE ARK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 16	21805			
	employees of or pe health care facility.	ersons providing service in a				
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide dignified toileting for 1 of 1 voiced complaints about d pan.				
	Findings include:					
	6/18/15, identified F	Imum Data Set (MDS) dated R7 had intact cognition, assistance with toileting, and vel incontinence.				
	an, "ADL [activities Performance Defici required, "Total ass hygiene/clothing/pro	ed 9/30/15, identified R7 had of daily living] Self Care it", and for toileting R7 ist to transfer and related oduct management. She is commode and bedpan [if				
	stated she used to the toilet/commode getting assistance w since, "They [staff] R7 stated she now to void, and she did "I like to do my buis the bathroom." R7 w	on 11/12/15, at 1:01 p.m. R7 receive help from staff to use , however had not been with using a commode or toilet dropped my out of the sling." was required to use a bed pan I not like it, "I hate it," adding, ness [void and defecate] in was unable to rmember if alternative toileting options.				
	dated 10/21/15, ide	nerapy) - Hospice Evaluation ntified an evaluation was ability to transfer to the				

STATE FORM

Minnesot	ta Department	of Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:								
		00643	B. WING		11/1	13/2015				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE					
21805	Continued From page 17		21805							
	the mechanical lift	er she sustained a fall out of sling. R7 was assessed to be et sling and use the commode								
	"Voiced frustration to toilet any longer and briefs." A subseque identified R7, "Voice use the bedpan [sice is too difficult to try Writer reminded he her to use the bedp notes identified the	dated 10/22/15, identified R7, that she could not use the d had to use a bed pan or her ent note dated 10/24/15, ed complaints about having to c] throughout the day. States it and poop in the bedpan. r that it is safer at this time for pan" None of the progress therapy screening completed th R7 was deemed safe to use transfer to the toilet.								
	nursing assistant (N complaints about ha	on 11/12/15, at 1:15 p.m. VA)-A stated R7 had voiced aving to use the bed pan ode or toilet adding R7 her butt."								
	registered nurse (R to toilet using a bed from the mechanica aware R7 was unha	on 11/12/15, at 1:48 p.m. N)-A stated R7 was assisted pan since she sustained a fall al lift. RN-A stated she was appy about having to use a the toilet or commode.								
	director of nursing (a bed pan for toileti safe to use a toilet s safe to transfer bec wouldn't do it right." concern for R7's dig	off would revisit the idea of								

Minnesota	Depai	rtment	of	Health

Maria .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00643	B. WING		11/	11/13/2015			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	, STATE, ZIP CODE					
STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET WAITE PARK, MN 56387									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE			
21805	Continued From page 18		21805						
	as being safe to use sling, the facility cor R7's elimination nee frustrations and wis A facility Dignity and dated 10/2015, ider care for residents ir environment that m resident's dignity ar his or her individual SUGGESTED MET The director of nurs all residents to assu- necessary treatmer in toileting. The direc could conduct rando care; to ensure app implemented.	d Privacy Guideline policy ntified staff should, "Promote a manner and in an aintains or enhances each nd respect in full recognition of							
Minnesota Dep STATE FORM	partment of Health		6899	94KU11		on sheet 19 of 19			

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