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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 94KU

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/20/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Mardelle Trettel, HFE NE II 01/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 02/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/16/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/31/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

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.

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 https://dab.efile.hhs.gov 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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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:

• 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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245375 Y1	A. Building B. Wing Y2	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	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		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 01/28/2016	SIGNATURE OF SURVEYOR 34987	DATE 01/20/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
11/13/2015

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245375 Y1	A. Building 01 - MAIN BUILDING 01 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	12/23/2015	LSC K0029	11/17/2015	LSC K0062	01/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0070	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		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	01/28/2016	34764	01/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/10/2015

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

MDH
Minnesota
Department
of Health

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,

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 / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00643 Y1	A. Building 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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20302	Correction	ID Prefix	20565	Correction	ID Prefix	20830	Correction
Reg. #	MN State Statute 144.6503	Completed	Reg. #	MN Rule 4658.0405 Subp. 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	Correction	ID Prefix	21805	Correction
Reg. #	MN Rule 4658.0525 Subp. 3	Completed	Reg. #	MN Rule 4658.1400	Completed	Reg. #	MN St. Statute 144.651 Subd. 5	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		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	BF/KJ	01/28/2016	34987	01/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/13/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 94KU

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 12/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/31/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/31/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Brenda.Fischer@state.mn.us
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

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,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

Sterling Park
SENIOR LIVING

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	11/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide dignified toileting for 1 of 1 residents (R7) who voiced complaints about having to use a bed pan. Findings include: R7's quarterly Minumum Data Set (MDS) dated 6/18/15, identified R7 had intact cognition, required extensive assistance with toileting, and had occasional bowel incontinence. R7's care plan dated 9/30/15, identified R7 had an, "ADL [activities of daily living] Self Care Performance Deficit", and for toileting R7	F 241	F 241 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:	

10/30/15 Ad addendum POC HF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Pohl	Executive Director	12.15.15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 required, "Total assist to transfer and related hygiene/clothing/product management. She is able to sit on toilet/commode and bedpan [if already in bed]." During an interview on 11/12/15, at 1:01 p.m. R7 stated she used to receive help from staff to use the toilet/commode, however had not been getting assistance with using a commode or toilet since, "They [staff] dropped my out of the sling." R7 stated she now was required to use a bed pan to void, and she did not like it, "I hate it," adding, "I like to do my buisness [void and defecate] in the bathroom." R7 was unable to rmember if facility had offered alternative toileting options. R7's PT (physical therapy) - Hospice Evaluation dated 10/21/15, identified an evaluation was completed of R7's ability to transfer to the toilet/commode after she sustained a fall out of the mechanical lift sling. R7 was assessed to be able to use the toilet sling and use the commode or toilet. R7's progress note dated 10/22/15, identified R7, "Voiced frustration that she could not use the toilet any longer and had to use a bed pan or her briefs." A subsequent note dated 10/24/15, identified R7, "Voiced complaints about having to use the bedpan [sic] throughout the day. States it is too difficult to try and poop in the bedpan. Writer reminded her that it is safer at this time for her to use the bedpan..." None of the progress notes identified the therapy screening completed on 10/21/15 in which R7 was deemed safe to use the toilet sling and transfer to the toilet. During an interview on 11/12/15, at 1:15 p.m. nursing assistant (NA)-A stated R7 had voiced	F 241	1. R7 continues to be evaluated by therapy for safety with use of toileting sling related to upper extremity weakness and ability to maintain self in the sling. R7 interviewed and continues to state she does not want to utilize hammock toileting sling in order to utilize toilet or commode. Resident only wishes to utilize toileting sling if able to do so safely. 2. All residents receive a comprehensive transfer and repositioning assessment upon admission, quarterly and with a significant change. 3. All staff will receive reeducation by December 23, 2015 regarding resident dignity and choice. 4. DNS or designee will conduct audits twice weekly for one month and then once weekly for two months on dignity and choice. The data collected will be reviewed/discussed at the monthly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies and required audits 5. DNS is responsible 6. Completion date 12-23-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 2 complaints about having to use the bed pan instead of a commode or toilet adding R7 complains it, "Hurts her butt." When interviewed on 11/12/15, at 1:48 p.m. registered nurse (RN)-A stated R7 was assisted to toilet using a bed pan since she sustained a fall from the mechanical lift. RN-A stated she was aware R7 was unhappy about having to use a bed pan instead of the toilet or commode. During interview on 11/13/15, at 7:48 a.m. the director of nursing (DON) stated R7 was kept on a bed pan for toileting despite being assessed as safe to use a toilet sling as they felt she wasn't safe to transfer because, "We were afraid staff wouldn't do it right." Further, DON stated it was a concern for R7's dignity with her voiced frustrations, and staff would revisit the idea of toileting for R7 again. Although R7 was assessed by physical therapy as being safe to use a mechanical lift and toileting sling, the facility continued to use a bed pan for R7's elimination needs despite her voiced frustrations and wishes not to do so. A facility Dignity and Privacy Guideline policy dated 10/2015, identified staff should, "Promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 3 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/19/15, indicated she was severely cognitively impaired and required extensive assistance with toileting, transfers, bed mobility and had a stage four pressure ulcer on her coccyx. R4's plan of care dated 10/29/15 indicated she was incontinent of bowel and bladder and had moisture associated skin damage along with a stage four pressure ulcer to sacral/coccyx area. The care plan directed staff to check R4 every hour for incontinence and reposition her side to side every hour while in bed. During a continuous observation on 11/12/15 from 1:00 p.m. to 2:27 p.m., R4 was observed lying on her back in bed. She had a pillow tucked under her left flank. R4's position remained unchanged for one hour and twenty seven minutes. During an interview on 11/12/15 at 2:29 p.m., NA-C stated she did not know the last time R4 had been repositioned. NA-C stated, the last shift "did not pass that along." NA-C further stated, R4 should be repositioned every hour.	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident R4 had an updated comprehensive skin and positioning evaluation completed on December 7th, 2015. R4 also had care plan reviewed and revised to reflect current care. 2. All residents with an identified alteration in skin had their care plan reviewed and revised to reflect current care. 3. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 4 During an interview on 11/12/15, at 2:33 p.m., registered nurse (RN)-A stated, R4 should bed repositioned every hour which was last completed at 1:00 p.m. She stated she was not sure who had laid R4 down at that time. During an interview on 11/12/15, at 2:47 p.m., the director of nursing (DON) stated, R4 should be turned and repositioned every hour. The DON also stated she was unsure who had laid R4 down after lunch. She stated she would expect the nurses to be be helping the nursing assistants to get R4 repositioned in a timely manner, as directed by the care plan. A facility policy regarding care planning was requested, but none were provided.	F 282	4. All nursing staff will receive reeducation by December 23, 2015 regarding plan of care. 5. DNS or Designee will audit 2 resident medical records per week for one month and then one weekly for two months to ensure interventions for impaired skin are followed. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. 6. DNS responsible 7. Completion date 12-23-15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and implement interventions to reduce discomfort for 1 of 3 residents (R4) identified with discomfort. Findings include:	F 309	F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 R4's quarterly Minimum Data Set (MDS) dated 10/19/15, identified R4 had severe cognitive impairment, and had a stage four pressure ulcer on her coccyx. R4's care plan dated 10/29/15 indicated R4 had limited physical mobility and acute pain in pressure ulcer as well as rheumatoid arthritis and osteoporosis. The care plan indicated, R4 has acute pain related to dressing changes to coccyx, but will immediately denies pain when asked. She does display some moaning, grimacing, and says, "Ow!" The care plan identified R4's acceptable level of pain as "0" out of "10" and directed staff to anticipate need for pain relief. A care area assessment dated 10/15/15 indicated R4 had a "history of back pain." The care plan further indicated that R4, denied all pain in the past 5 days, however, personal observation as well as staff interviews, identify that R4 displays some pain indicators and complains of pain during dressing changes. The assessment indicated R4's overall goal is "to be as pain free as possible." During a dressing change observation on 11/12/15, at 7:38 a.m., R4 stated "ouch, ouch, that hurts", while RN-A performed a dressing change to her coccyx. R4 had not other non-verbal signs of discomfort. When the dressing change was completed, RN-A stated that during the weekly wound rounds, R4 "doesn't typically have discomfort with dressing changes." RN-A stated that R4 did not have and scheduled pain medication prior to coccyx dressing change. On 11/12/15 at 8:24 a.m., RN-A and human resources manager (HRM) entered R4's room to	F 309	1. R4 had a Comprehensive Pain evaluation completed on 12-15-14. Care Plan has been reviewed and revised to reflect current care needs. 2. All residents receive a Comprehensive Pain assessment upon admission, quarterly, with a significant change. Pain is monitored daily with care and pre and post pain medication administration. 3. All nursing staff will receive re-education regarding pain management by 12-23-15. 4. DNS or designee will complete audits twice a week for a month and once a week 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. 5. DNS responsible 6. Completion date 12-23-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	11/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 perform morning cares. RN-A and HRM were observed changing R4's incontinent product. As registered nurse (RN)-A was washing R4's bottom, R4 stated, "Ow, I don't like that, I don't like that at all." During an interview on 11/13/15, at 8:40 a.m., nursing assistant (NA)-B (who routinely performs R4's morning cares), stated R4 has discomfort with cares, especially with her bottom. During and interview on 11/13/15, at 8:40 a.m., licensed practical nurse (LPN)-A stated, R4 complains of discomfort with transfers, wound care, and movement. LPN-A stated R4 received only Tylenol for pain relief as needed, and was not receiving any scheduled pain medications. LPN-A further stated, R4 had only received Tylenol two times during the month of November 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	F 309		

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F 309	Continued From page 7 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 medication record, there was no evidence that staff asked or observed R4 for pain. during the review of the every three day dressing changes, the nursing staff documented R4's reported pain as "0", even though R4 received a dressing change to her coccyx every 3 days. Most of the days, it did not identify what R4 rated her pain. 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 11/12/15 at approximately 9:49 a.m., and received a subsequent order for Tylenol prior to dressing changes. During an interview on 11/13/15, at 8:52 a.m., the director of nursing (DON) stated, R4 has not had any consistent complaints of pain and that staff ask R4 about pain during her dressing changes and was a reliable reporter. The DON further stated if R4 was having pain, the nursing assistants would notify the nurse who would ask R4 about her pain level. She stated she would expect the nurses to follow through with what is care planned. 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 dressing change, during transfers and with	F 309		

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F 309	Continued From page 8 personal cares. A facility policy labeled Pain Management, dated 2015 indicated its purpose: to provide guidelines for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. The policies guidelines included but were not limited to: Recognize and report pain, intervene to treat pain before pain becomes severe and to prevent or minimize anticipated pain (during procedures, cares and treatments)	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete timely repositioning for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/16/15, identified R4 had severe cognitive	F 314	F314 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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F 314	Continued From page 9 impairment, required extensive assistance with activities of daily living (ADLs), had a stage IV pressure ulcer (total loss of skin extending into muscle and bone), and was on a, "Turning/reposition program." R4's Pressure Ulcer Care Area Assessment (CAA) dated 7/16/15, identified R4 had an existing pressure ulcer, and required a regular schedule of turning and repositioning. R4's Braden assessment dated 10/15/15, identified R4 to be at moderate risk of pressure ulcer development. R4's care plan dated 10/29/15, identified R4 had, "Potential for pressure ulcer development," and directed staff to, "Reposition per individual needs: Hourly side to side in bed, up for meals, selected activities and dialysis only." During observation of wound care on 11/12/15, at 7:36 a.m. registered nurse (RN)-A changed a dressing on R4's coccyx. RN-A measured the stage IV pressure ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures) was measured to be 4.5 cm (centimeters) by 0.5 cm by 0.5 cm, with a wound base of bright red granulation tissue. The skin immediately surrounding the pressure ulcer was bright red in colored and appeared macerated (white coloration). During continuous observation on 11/12/15, from 1:00 p.m. to 2:27 p.m., R4 was laying in her bed on her back, with a pillow tucked under her left side. She remained in this position without being repositioned or offered to be repositioned for one hour and twenty seven minutes even though R4	F 314	1. R4 had a comprehensive skin and positioning evaluation completed on December 7th, 2015 and care plan reviewed and revised to reflect current cares. 2. 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. 3. All nursing staff will receive re-education by December 23, 2015 regarding plan of care. 4. DNS or designee will complete two audits weekly for one month, and then one 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 5. DNS is responsible 6. Completion date 12-23-15	

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F 314	Continued From page 10 had a stage IV pressure ulcer on her coccyx. When interviewed about repositioning for R4 on 11/12/15, at 2:29 p.m. nursing assistant (NA)-C stated she was unaware when R4 was last repositioned adding the prior shift, "Did not pass that [information] along." Further, NA-C stated R4 should be repositioned every hour when in bed as care planned. Staff repositioned R4 at that time. During interview on 11/12/15, at 2:33 p.m. RN-A stated R4 should be repositioned every hour when in bed. When interviewed on 11/12/15, at 2:47 p.m. the director of nursing (DON) stated R4 should have been repositioned every one hour when in bed, and added the nurses were expected to help the NA staff to make sure R4 was repositioned timely. A facility Pressure Ulcer Prevention policy dated October 2015, identified a purpose of, "Promote the prevention of alteration in skin integrity; promote healing of current skin alterations and to prevent further loss of skin integrity." Further, the policy directed staff to develop care plan approaches (i.e. repositioning) to reduce or stabilize a resident's risk factors and promote healing of pressure ulcers.	F 314		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 10, 2015. At the time of this survey, Building 01 of Sterling Park Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok 12-29-15 RECEIVED DEC 29 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Executive Director | 12.14.15

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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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 01 of Sterling Park Healthcare Center was constructed as follows: The original building was built in 1963, is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction; The 1983 building addition is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction The 2003 building addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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K 000	Continued From page 2 corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 53 beds and had a census of 37 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had several corridor room doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of 12 patients, staff and visitors, if smoke	K 018	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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K 018	Continued From page 3 were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 08:30 AM to 11:30 AM on 11/10/2015, it was observed that: 1. The corridor door for resident room E-11, E-14, E-18, W-12, W-14 would not positively latch into its frame. This deficient condition was verified by the Director of Maintenance (MF).	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 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to	K 029	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 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:	

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K 029	Continued From page 4 spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 08:30 AM to 11:30 AMon 11/10/2015, observation revealed, that the following deficient conditions hazardous storage rooms throughout the facility: 1. Resident room W-1 was converted into a storage room and are not equipped with self closing doors. This deficient condition was verified by the Director of Maintenance (MF).	K 029	1. 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 2. FMD will ensure self closure remains on door to W-1 as long as room is being used for storage	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1 and 2-2.2. This deficient practice could affect all 37 out 53 residents.	K 062	K 062 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	

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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. This deficient condition was verified by the Director of Maintenance (MF).	K 062	1. Per the FMD the non-compliant sprinkler heads have been 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 sprinklers heads monthly to insure compliance with LSC requirements.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 19.7.8. This deficient practice could affect 8 of 37 residents, visitors and staff. Findings include:	K 070	K 070 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:	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	Continued From page 6 On facility tour between 08:30 AM and 11:30AM on 11/10/2015, it was observed that there was an unapproved portable space heater found next to a sleeping resident in a resident room. This portable heater was accessible to other residents and visitors. At the time of the inspection the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by the Director of Maintenance (MF).	K 070	1. 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 2. All staff will be educated on the NO space heater policy by: 12/23/2015 3. FMD will verify the policy is being followed monthly during sprinkler head inspections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING **02 - 2010 ADDTION** B. WING _____	**11/10/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 16, 2014. At the time of this survey, Building 02 of Sterling Park Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok 12-29-15 RECEIVED DEC 29 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Executive Director 12.14.15

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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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Sterling Park Healthcare Center consists of the 2010 Courtyard Great Room addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 53 beds and had a census of 37 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET as evidenced by:	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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

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
Brenda.Fischer@state.mn.us
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,

Kamala Fiske-Downing

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00643	A. BUILDING: _____ B. WING _____	11/13/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On November 9, 10, 12 and 13, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000	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.	

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000	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 which 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 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.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide to residents and/or interested family members information regarding: Alzheimer's training staff received, who received training, how often, and a description of the training provided. This had the potential to affect all current residents of the facility and their families. Findings include: A review of the facility's Alzheimer's training, a computer-based program from Relias Learning, copyrighted 2014, indicated the course modules included: managing challenging behaviors; a philosophy and concepts in caring for people with Alzheimer's dementia; therapeutic activity	2 302		

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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. During review of admission forms and documents provided to resident of the facility indicated there was no information regarding Alzheimer'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 Alzheimer's training is provided to the staff, which staff were trained and how often. The SW said the facility does talk about dementia care "with family and consumers at care conferences," and at "resident council" and also "on an individual basis with both residents and family." The SW stated, the facility "does not have" a formal document that is provided regarding the staff Alzheimer training. SUGGESTED METHOD OF CORRECTION: 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		

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2 565	Continued From page 4	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/19/15, indicated she was severely cognitively impaired and required extensive assistance with toileting, transfers, bed mobility and had a stage four pressure ulcer on her coccyx. R4's plan of care dated 10/29/15 indicated she was incontinent of bowel and bladder and had moisture associated skin damage along with a stage four pressure ulcer to sacral/coccyx area. The care plan directed staff to check R4 every hour for incontinence and reposition her side to side every hour while in bed. During a continuous observation on 11/12/15 from 1:00 p.m. to 2:27 p.m., R4 was observed lying on her back in bed. She had a pillow tucked under her left flank. R4's position remained unchanged for one hour and twenty seven minutes.	2 565		

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2 565	Continued From page 5 During an interview on 11/12/15 at 2:29 p.m., NA-C stated she did not know the last time R4 had been repositioned. NA-C stated, the last shift "did not pass that along." NA-C further stated, R4 should be repositioned every hour. During an interview on 11/12/15, at 2:33 p.m., registered nurse (RN)-A stated, R4 should bed repositioned every hour which was last completed at 1:00 p.m. She stated she was not sure who had laid R4 down at that time. During an interview on 11/12/15, at 2:47 p.m., the director of nursing (DON) stated, R4 should be turned and repositioned every hour. The DON also stated she was unsure who had laid R4 down after lunch. She stated she would expect the nurses to be be helping the nursing assistants to get R4 repositioned in a timely manner, as directed by the care plan. A facility policy regarding care planning was requested, but none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to assure they are receiving the treatment/services as directed by the plan of care. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		

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2 830	Continued From page 6 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and implement interventions to reduce discomfort for 1 of 3 residents (R4) identified with discomfort. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/19/15, identified R4 had severe cognitive impairment, and had a stage four pressure ulcer on her coccyx. R4's care plan dated 10/29/15 indicated R4 had limited physical mobility and acute pain in pressure ulcer as well as rheumatoid arthritis and osteoporosis. The care plan indicated, R4 has acute pain related to dressing changes to coccyx, but will immediately denies pain when asked. She does display some moaning, grimacing, and says, "Ow!" The care plan identified R4's acceptable level of pain as "0" out of "10" and directed staff to anticipate need for pain relief. A care area assessment dated 10/15/15 indicated	2 830		

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2 830	Continued From page 7 R4 had a "history of back pain." The care plan further indicated that R4, denied all pain in the past 5 days, however, personal observation as well as staff interviews, identify that R4 displays some pain indicators and complains of pain during dressing changes. The assessment indicated R4's overall goal is "to be as pain free as possible." During a dressing change observation on 11/12/15, at 7:38 a.m., R4 stated "ouch, ouch, that hurts", while RN-A performed a dressing change to her coccyx. R4 had not other non-verbal signs of discomfort. When the dressing change was completed, RN-A stated that during the weekly wound rounds, R4 "doesn't typically have discomfort with dressing changes." RN-A stated that R4 did not have and scheduled pain medication prior to coccyx dressing change. On 11/12/15 at 8:24 a.m., RN-A and human resources manager (HRM) entered R4's room to perform morning cares. RN-A and HRM were observed changing R4's incontinent product. As registered nurse (RN)-A was washing R4's bottom, R4 stated, "Ow, I don't like that, I don't like that at all." During an interview on 11/13/15, at 8:40 a.m., nursing assistant (NA)-B (who routinely performs R4's morning cares), stated R4 has discomfort with cares, especially with her bottom. During and interview on 11/13/15, at 8:40 a.m., licensed practical nurse (LPN)-A stated, R4 complains of discomfort with transfers, wound care, and movement. LPN-A stated R4 received only Tylenol for pain relief as needed, and was not receiving any scheduled pain medications. LPN-A further stated, R4 had only received Tylenol two times during the month of November	2 830		

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2 830	Continued From page 8 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 medication record, there was no evidence that staff asked or observed R4 for pain. during the review of the every three day dressing changes, the nursing staff documented R4's reported pain as "0", even though R4 received a dressing change to her coccyx every 3 days. Most of the days, it did not identify what R4 rated her pain. 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 11/12/15 at approximately 9:49 a.m., and received a subsequent order for Tylenol prior to dressing changes.	2 830		

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2 830	Continued From page 9 During an interview on 11/13/15, at 8:52 a.m., the director of nursing (DON) stated, R4 has not had any consistent complaints of pain and that staff ask R4 about pain during her dressing changes and was a reliable reporter. The DON further stated if R4 was having pain, the nursing assistants would notify the nurse who would ask R4 about her pain level. She stated she would expect the nurses to follow through with what is care planned. 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 dressing change, during transfers and with personal cares. A facility policy labeled Pain Management, dated 2015 indicated its purpose: to provide guidelines for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. The policies guidelines included but were not limited to: Recognize and report pain, intervene to treat pain before pain becomes severe and to prevent or minimize anticipated pain (during procedures, cares and treatments) SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to assure they are receiving the necessary treatment/services to to ensure approperiate pain managment is in place for all residents as appropriate. The director of nursing	2 830		

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	00643	A. BUILDING: _____ B. WING _____	11/13/2015

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2 830	Continued From page 10 or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete timely repositioning for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/16/15, identified R4 had severe cognitive	2 900		

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2 900	Continued From page 11 impairment, required extensive assistance with activities of daily living (ADLs), had a stage IV pressure ulcer (total loss of skin extending into muscle and bone), and was on a, "Turning/reposition program." R4's Pressure Ulcer Care Area Assessment (CAA) dated 7/16/15, identified R4 had an existing pressure ulcer, and required a regular schedule of turning and repositioning. R4's Braden assessment dated 10/15/15, identified R4 to be at moderate risk of pressure ulcer development. R4's care plan dated 10/29/15, identified R4 had, "Potential for pressure ulcer development," and directed staff to, "Reposition per individual needs: Hourly side to side in bed, up for meals, selected activities and dialysis only." During observation of wound care on 11/12/15, at 7:36 a.m. registered nurse (RN)-A changed a dressing on R4's coccyx. RN-A measured the stage IV pressure ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures) was measured to be 4.5 cm (centimeters) by 0.5 cm by 0.5 cm, with a wound base of bright red granulation tissue. The skin immediately surrounding the pressure ulcer was bright red in colored and appeared macerated (white coloration). During continuous observation on 11/12/15, from 1:00 p.m. to 2:27 p.m., R4 was laying in her bed on her back, with a pillow tucked under her left side. She remained in this position without being repositioned or offered to be repositioned for one hour and twenty seven minutes even though R4 had a stage IV pressure ulcer on her coccyx.	2 900		

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2 900	Continued From page 12 When interviewed about repositioning for R4 on 11/12/15, at 2:29 p.m. nursing assistant (NA)-C stated she was unaware when R4 was last repositioned adding the prior shift, "Did not pass that [information] along." Further, NA-C stated R4 should be repositioned every hour when in bed as care planned. Staff repositioned R4 at that time. During interview on 11/12/15, at 2:33 p.m. RN-A stated R4 should be repositioned every hour when in bed. When interviewed on 11/12/15, at 2:47 p.m. the director of nursing (DON) stated R4 should have been repositioned every one hour when in bed, and added the nurses were expected to help the NA staff to make sure R4 was repositioned timely. A facility Pressure Ulcer Prevention policy dated October 2015, identified a purpose of, "Promote the prevention of alteration in skin integrity; promote healing of current skin alterations and to prevent further loss of skin integrity." Further, the policy directed staff to develop care plan approaches (i.e. repositioning) to reduce or stabilize a resident's risk factors and promote healing of pressure ulcers. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented.	2 900		

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2 900	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21665	MN Rule 4658.1400 Physical Environment 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: During observation of resident rooms on 11/9/15, at approximately 2:30 p.m., the following rooms were noted to have water from the faucets that felt uncomfortably hot to the touch: > West (W)2, W12, W15, W17; > East (E)6, E10, E11, E13, E15, and E17. A review of facility incident reports from 5/1/2015 to 11/9/2015 indicated there were no residents who sustained burns or who had incidents related to use of hot water in the facility. During a tour of the facility on 11/9/15, at 3:01 p.m. in the presence of the surveyor, maintenance assistant (MA)-A, measured hot water temperatures from bathroom faucets in the	21665		

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21665	Continued From page 14 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 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. 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, the MD did not record which thermometer type 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." During a subsequent interview on 11/13/15, at	21665		

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21665	Continued From page 15 12:25 p.m. MD stated the elevated hot water temperatures had been a "recurring problem," adding, "I [now] believe the problem is solved." MD stated he was unaware of any steps the staff were taking to reduce the risk of burns to residents in the facility despite having problems in the past with hot water. During an interview on 11/13/15, at 12:30 p.m. the administrator stated the facility was working with a plumber to resolve the hot water issues. In the past when the water temperature would become too hot, the temperatures were checked more frequently, but the administrator was unable to provide any documentation for it. A policy was requested regarding hot water temperatures but none was provided. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee, could review all water temperature logs to ensure resident, staff and visitor safety in regard to potential for burns. The administrator or designee, could conduct random audits of the water temperatures and logs to ensure safe water temperatures are maintained and policies and procedures are consistently implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by	21805		

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21805	Continued From page 16 employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide dignified toileting for 1 of 1 residents (R7) who voiced complaints about having to use a bed pan. Findings include: R7's quarterly Minumum Data Set (MDS) dated 6/18/15, identified R7 had intact cognition, required extensive assistance with toileting, and had occasional bowel incontinence. R7's care plan dated 9/30/15, identified R7 had an, "ADL [activities of daily living] Self Care Performance Deficit", and for toileting R7 required, "Total assist to transfer and related hygiene/clothing/product management. She is able to sit on toilet/commode and bedpan [if already in bed]." During an interview on 11/12/15, at 1:01 p.m. R7 stated she used to receive help from staff to use the toilet/commode, however had not been getting assistance with using a commode or toilet since, "They [staff] dropped my out of the sling." R7 stated she now was required to use a bed pan to void, and she did not like it, "I hate it," adding, "I like to do my buisness [void and defecate] in the bathroom." R7 was unable to rmember if facility had offered alternative toileting options. R7's PT (physical therapy) - Hospice Evaluation dated 10/21/15, identified an evaluation was completed of R7's ability to transfer to the	21805		

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21805	Continued From page 17 toilet/commode after she sustained a fall out of the mechanical lift sling. R7 was assessed to be able to use the toilet sling and use the commode or toilet. R7's progress note dated 10/22/15, identified R7, "Voiced frustration that she could not use the toilet any longer and had to use a bed pan or her briefs." A subsequent note dated 10/24/15, identified R7, "Voiced complaints about having to use the bedpan [sic] throughout the day. States it is too difficult to try and poop in the bedpan. Writer reminded her that it is safer at this time for her to use the bedpan..." None of the progress notes identified the therapy screening completed on 10/21/15 in which R7 was deemed safe to use the toilet sling and transfer to the toilet. During an interview on 11/12/15, at 1:15 p.m. nursing assistant (NA)-A stated R7 had voiced complaints about having to use the bed pan instead of a commode or toilet adding R7 complains it, "Hurts her butt." When interviewed on 11/12/15, at 1:48 p.m. registered nurse (RN)-A stated R7 was assisted to toilet using a bed pan since she sustained a fall from the mechanical lift. RN-A stated she was aware R7 was unhappy about having to use a bed pan instead of the toilet or commode. During interview on 11/13/15, at 7:48 a.m. the director of nursing (DON) stated R7 was kept on a bed pan for toileting despite being assessed as safe to use a toilet sling as they felt she wasn't safe to transfer because, "We were afraid staff wouldn't do it right." Further, DON stated it was a concern for R7's dignity with her voiced frustrations, and staff would revisit the idea of toileting for R7 again.	21805		

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21805	Continued From page 18 Although R7 was assessed by physical therapy as being safe to use a mechanical lift and toileting sling, the facility continued to use a bed pan for R7's elimination needs despite her voiced frustrations and wishes not to do so. A facility Dignity and Privacy Guideline policy dated 10/2015, identified staff should, "Promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to assure they are receiving the necessary treatment/services to promote dignity in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		