



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 23, 2025

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

RE: CCN: 245375

Cycle Start Date: August 1, 2025

Dear Administrator:

On August 20, 2025, we notified you a remedy was imposed. On September 18, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 7, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 4, 2025 is discontinued as of September 7, 2025. (42 CFR 488.417 (b))

In our letter of August 20, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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Electronically delivered

September 23, 2025

Administrator
STERLING PARK HEALTH CARE CENTER

142 NORTH FIRST STREET
WAITE PARK, MN 56387

Re: Reinspection Results
Event ID: REY712

Dear Administrator:

On September 18, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

August 20, 2025

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

RE: CCN: 245375

Cycle Start Date: August 1, 2025

Dear Administrator:

On August 1, 2025, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 29, 2025, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 4, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 4, 2025 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 4, 2025 the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility.

Therefore, STERLING PARK HEALTH CARE CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 4, 2025. You will receive further information regarding this from the State agency.

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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
The date that each deficiency will be corrected.
An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE 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 February 1, 2026 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

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:

tamika.brown@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
202-795-7490

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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & 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

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/01/2025	
NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 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	
E0000	Initial Comments On 7/28/25 to 8/1/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/28/2025	
F0000	INITIAL COMMENTS On 7/28/25 through 8/1/25 a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F578 began on 7/28/25, when the facility failed to ensure advanced directives were accurately documented on the resident's electronic health record (EHR) banner, physician orders and Physician's Orders for Life Saving Treatment (POLST) The director of nursing (DON) was notified of the IJ on 7/28/25 at 5:55 p.m. The IJ was removed on 7/29/25 at 10:56 a.m. The following complaints were reviewed with NO deficiencies cited: H53759948C (MN00103391) H53759875C (MN00106092) H53759876C (MN00108135)		F0000			08/28/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000	Continued from page 1 H53759947C (MN00110943) HL241021080C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				
F0578 SS = J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the		F0578	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by updating the electronic medical record to match the POLST for R35 and R16 on 7/28/2025 and auditing all residents' code status for accuracy on 7/28/2025. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff were educated by 7/29/2025 on the facility process for utilizing the hard copy Advance Directive/POLST for CPR administration by DON. To ensure Advance Directive/POLST are processed correctly all licensed staff were educated by 9/4/2025 on the process for transcribing Advance Directive/POLST orders into the electronic and hard chart medical record. The DON and/or designee will audit all admissions and 2 additional random other residents weekly for 4 weeks and to ensure the electronic medical record and hard copy POLST/Advance Directive match. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/04/2025	

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F0578 SS = J	Continued from page 2 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow process to ensure advanced directives were accurately documented and updated on the resident's electronic health record (EHR) banner, physician orders and Physician's Orders for Life Saving Treatment (POLST) which affected 2 of 16 residents (R35 and R19) reviewed for advance directives. These findings constituted an immediate jeopardy (IJ) situation for R35 and R19 who would not have received cardiopulmonary resuscitation measures (CPR) according to their wishes. The IJ began on 11/26/24, when R35's POLST, indicating R35's wishes for resuscitation was signed by the medical provider and it was not changed within the facility's EHR to reflect R35's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care staff outlined they would implement the incorrect directions and not perform CPR which was against R35's wishes due to this error. The director of nursing (DON) was notified of the IJ on 7/28/25 at 5:55 p.m. The IJ was removed on 7/29/25 at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. The director of nursing (DON) was notified of the IJ on 7/28/25 at 5:55 p.m. The IJ was removed on 7/29/25 at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R35's quarterly Minimum Data Set (MDS) dated 5/1/25, identified R35 had intact cognition and required assistance with all activities of daily living (ADL)'s. R35's diagnoses included acute on chronic systolic		F0578				

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F0578 SS = J	Continued from page 3 (congestive) heart failure, hypertension, renal failure, diabetes mellitus, and chronic respiratory failure with hypoxia. R35's electronic health record (EHR) banner reviewed on 7/28/25 at 4:18 p.m., identified R35 was do not resuscitate/do not intubate (DNR/DNI). R35's Order Summary report dated 7/28/25, indicated DNR/DNI status. R35's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse's station, signed by R35 and medical doctor (MD)-A on 11/26/24 indicated full code status. During interview on 7/28/25 at 3:02 p.m., trained medication aide (TMA)-A stated she would refer to the banner in the EHR, in the event of an emergency, regarding resident's code status. TMA-A confirmed R35's code status stated DNR/DNI. TMA-A stated they would take no action, except to notify the nurse, in the event R35 was without breath or heartbeat. According to information noted in R35's EHR, TMA-A stated they would alert the nurse R35 was do not resuscitate/do not intubate. During interview on 7/28/25 at 3:04 p.m., nursing assistant (NA)-A stated she would refer to the banner on the computer or tablet regarding resident's code status. During interview on 7/28/25 at 4:29 p.m., R35 stated if her heart stopped, she would want cardiopulmonary resuscitation (CPR) to resuscitate her. During interview on 7/28/25 at 4:31 p.m., director of nursing (DON) stated her expectations would be for staff to look at the emergency red binder located in the nurse's station in the event of an emergency at the actual signed POLST for code status. If code status orders do not match, there would be a high risk of initiating the wrong life-saving treatments. DON looked at POLST that was in the emergency red binder and confirmed code status was changed to full code on 11/26/24 and was signed by both R35 and the provider. DON then confirmed the banner and order in the EHR stated code status as DNR/DNI and the order date on it was 7/20/23. DON confirmed the providers order from		F0578				

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F0578 SS = J	Continued from page 4 11/26/24 had gotten missed and that R35 would not have received CPR in the event of an emergency. R19's R19's admission Minimum Data Set (MDS) dated 6/6/25, identified R19 had intact cognition and required assistance with all activities of daily living (ADL)'s. R19's diagnoses included type II diabetes mellitus (DM) with polyneuropathy, hypothyroidism, hypertension, and chronic kidney disease stage 3. R19's electronic health record (EHR) banner reviewed on 7/28/25 at 3:20 p.m., identified R19 was do not resuscitate (DNR). R19's Order Summary report dated 7/28/25, indicated DNR status. R19's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse's station, signed by R19 on 5/21/25 indicated full code status. R19's Directives to Define Scope of Medical Care form, signed by R19 and dated 5/21/25, indicated TO RESUSCITATE. Both forms were signed by certified nurse practitioner (CNP)-A on 5/22/25 and were scanned into R19's EHR. During interview on 7/28/25 at 3:00 p.m., R19 stated she wanted cardiopulmonary resuscitation (CPR) to be performed if necessary, but she did not "want all the tubes and stuff". During interview on 7/28/25 at 3:03 p.m., licensed practical nurse (LPN)-B stated she would refer to the banner in the EHR, in the event of an emergency. If she did not have access, she would look in the binder kept in the nurses charting room. LPN-B accessed PCC and confirmed R19's banner indicated DNR. LPN-B stated if there was a discrepancy she would call the residents family member or power of attorney if they had one to determine the residents wishes. LPN-B stated, if R19's heart stopped or R19 stopped breathing, she would not initiated CPR as directions in PCC were DNR. During interview on 7/28/25 at 3:57 p.m., Director of Nursing (DON) stated during the admission process they completed an initial form named Directives to Define Scope of Medical Care, indicating the residents wishes and code status. That form was temporary, until the		F0578				

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NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 56387			
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F0578 SS = J	Continued from page 5 medical provider comes in and the completes the POLST form with the resident and/or Power of Attorney (POA). Once the POLST was completed it was scanned into the EHR and then placed in the red binders at the nurse's station. The Case Manager was responsible for obtaining orders signed by the medical provider and entering the order into the residents EHR which pulled into the banner. DON stated if there were a discrepancy the care staff know to use the POLST/binder. DON stated she felt the orders should be double checked by another nurse. DON stated CNP-A was usually good about telling them if there was a change, and the residents code status was also supposed to be reviewed with the resident and/or family during care conferences quarterly and annually and this was handled by the social worker. DON stated her expectation in the event of a medical emergency, was for staff to go directly to the red POLST binder, rather than trying to log in to the EHR. If there were a discrepancy there would not have been time to call a POA for clarification. DON stated if they found a discrepancy while performing chart audits, they would have followed up with the resident/POA to determine their wishes and then make sure it is reflected in the banner and the POLST. During interview on 7/28/25 at 4:30 p.m., social services (SS)-A stated she pulled the code status off the EHR and checked the advanced directives documents such as POLST, to verify accuracy as well as any POA or legal guardianship paperwork when she prepared for resident's care conferences. SS-A stated she verbalized the current code status, and asked the resident and/or POA if that is still their wishes. If resident or POA had not agreed, she would have corrected this with them. During interview on 7/29/25 at 10:51 a.m., trained medication aide (TMA)-C- stated she recently received education regarding resident POLST's. TMA-C stated in the event of a medical emergency, she would look in the red binder, which is alphabetized by residents last name, to locate the necessary residents' POLST. TMA-C stated the training entailed reading the information provided, followed by a verbal quiz on the information. During interview on 7/29/25 at 10:55 a.m., nursing assistant (NA)-D stated he received training last night about CPR and code statuses. He stated they are to look in the red binders at the nurses' station. NA-D stated he was told how he was to determine code status, and that the nurse was to make the call. In the event of an		F0578				

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F0578 SS = J	Continued from page 6 emergency someone checked the POLST kept at the nurses' station in two red binders filed alphabetically. NA-D stated the DON spoke with him and signed off on his retraining. The facility policy Cardiopulmonary Resuscitation (CPR) dated 4/21/25, identified it was the policy of the facility to adhere to resident's rights to formulate advance directives. Advance Directives to define the scope of medical care will be discussed with the potential resident and/or resident representatives at the time of admission. The facility will review decisions about a resident's CPR status at each initial care conference, at quarterly care conferences, at resident and/or resident representative request as well as at the time of any permanent, significant change in the resident's status that results in the development of a new care plan. The IJ was removed on 7/29/25 at 10:56 a.m., when the facility developed and implemented a systematic removal plan which was verified by interview and document review. On 7/28/25, the facility completed an audit of all residents' code status, reviewed the process to ensure the entered POLST information into the EMR was accurate and updated. On 7/28/25 licensed staff were educated regarding the updated POLST procedure and where to find a residents' code status. and continued for staff prior to their next shift. During interview on 8/1/25 at 11:45 a.m., director of operations (DOO) stated the facility did not have an advance directive policy. DOO stated the POLST should have been processed and entered in the EHR as any other provider order.	F0578		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0604	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by removing the parameter mattress for R21 on 8/25/2025 and auditing all other residents with parameter mattresses for potential restraints by 9/4/2025. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 9/4/2025 on the facility policy for restraints by ED/DON. The DON and/or designee will audit 2 random residents per week for 4 weeks to ensure no restraints	09/07/2025

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F0604 SS = D	Continued from page 7 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure parameter mattress (a type of mattress cover, or encasement designed to create a gentle barrier around the edge of the bed, preventing falls) was not used in a manner to restrain resident while in bed for 1 of 1 resident (R21) reviewed for restraints. Findings include: R21's annual Minimum Data Set (MDS) dated 6/10/25, identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. MDS did not indicate R21 utilized restraints. R21's care plan reviewed 7/31/25, identified R21 had limited physical mobility with fall risk related to weakness and limited mobility and had no recent history of falls. Care plan indicated R21 had a lipped mattress		F0604	Continued from page 7 are identified. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.			

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F0604 SS = D	Continued from page 8 initiated on 6/21/23, to decrease the risk of falls when sitting on edge of bed and low bed to limit injuries from falls. Care plan indicated R21 was non-ambulatory and needed assistance from two staff for bed mobility and transfers. During review of R21's electronic health record (EHR), Physical Device assessment completed on 6/9/25 indicated R21 utilized grab bars that were on bed and a wheelchair. Physical device assessment did not identify the parameter mattress was assessed or utilized by R21. During observation and interview on 7/28/25 at 1:48 p.m., R21's bed had a parameter mattress in place. R21 stated she was not sure why she had the parameter mattress on the bed and she does not attempt to get out of bed by herself as she knows she is not strong enough and she waits for staff for assistance. During interview on 7/31/25 at 3:22 p.m., licensed practical nurse (LPN)-A confirmed R21 had a parameter mattress present on bed. LPN-A stated R21 was not able to get out of bed by herself and has not tried to get out of bed by herself for some time. During interview on 8/1/25 at 10:39 a.m., nursing assistant (NA)-A stated R21 had a parameter mattress in place that has been there for several years to assist R21 with not falling out of bed. NA-A stated R21 was not able to reposition herself and was not able to get out of bed by herself for approximately the past year. During interview on 8/1/25 at 10:46 a.m., NA-B stated R21 had a parameter mattress present to assist R21 with not falling out of bed. NA-B stated R21 no longer attempts to get out of her bed independently and has not for quite a while. During interview on 8/1/25 at 11:32 a.m., registered nurse clinical coordinator (RN)-A, registered nurse clinical coordinator (RN)-B and director of nursing (DON) stated R21 needed assistance to get out of bed, was a fall risk and confirmed R21 had a parameter mattress in place. Parameter mattresses were assessed through the physical device assessment and should be assessed quarterly or with a change in condition. DON stated parameter mattresses helped resident identify the edge of the bed. The mattress could be considered a	F0604		

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F0604 SS = D	Continued from page 9 restraint when it was used to prevent the resident from getting out of bed or if resident was immobile. DON confirmed R21's parameter mattress was not assessed or mentioned on the physical device assessment and should have been. RN-A, RN-B and DON stated they are not sure why R21 still had the parameter mattress in place. The facility Restraint Free Environment policy, dated 2/23/25, indicated it was the policy of the facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. "Physical Restraint" refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot be removed easily which restricts freedom of movement or normal access to one's body. Physical restraints may include but are not limited to placing a resident on a concave mattress so that the resident cannot independently get out of bed. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint.		F0604				
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following:		F0628	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by completing a recap of stay for R40 on 7/29/2025. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 9/4/2025 on the facility discharge documentation guideline/policy by ED/DON. The DON and/or designee will audit all discharges weekly for 4 weeks to ensure appropriate documentation is completed. 3. As part of Sterling Park Healthcare Center's ongoing		09/04/2025	

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F0628 SS = D	Continued from page 10 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this			F0628	Continued from page 10 commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F0628 SS = D	Continued from page 11 section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible		F0628				

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F0628 SS = D	Continued from page 12 for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to		F0628				

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F0628 SS = D	Continued from page 13 the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review, the facility failed to ensure that a safe and orderly discharge was arranged for 1 of 2 residents (R40) who was discharged against medical advice (AMA). The facility did not complete a comprehensive discharge plan, or adequate documentation of efforts to educate the resident about the risks of leaving AMA. Findings Include: R40's quarterly Minimum Data Set (MDS) dated 7/10/25, identified R40 had intact cognition and required minimal or limited assistance with activities of daily living (ADL)'s. R40's diagnoses included type II diabetes mellitus (DM) with other specified complication, major depressive disorder, hypertension, bilateral primary osteoarthritis of knee, postprocedural; hypothyroidism, and hyperlipidemia. R40's quarterly care conference dated 6/10/25 noted resident plan to discharge to assisted living (AL) facility once medical assistance (MA) was open. R40 would need outpatient therapy, assistance with medication management, and a "commode with bars that		F0628				

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F0628 SS = D	Continued from page 14 goes over the toilet”. R40’s order summary report dated 6/30/25 noted discharge plan as home, alone. R40’s Notice of Medicare Non-Coverage (NOMNC) listed last covered date (LCD) as 2/6/25. Review of R40’s progress notes dated 7/18/25, indicated R40 left the facility with her daughter for an appointment and expressed intent to leave the facility AMA on 7/18/25. R40’s daughter informed the facility of intent to return to gather resident’s belongings and noted R40’s refusal to enter the building. An AMA form was taken out to resident in a vehicle to sign. AMA form dated 7/18/25 at 12p, was signed by R40 as well as social worker (SS)-A was scanned into R40's EHR. No documentation of recapitulation of stay or discharge summary was noted in R40's electronic health record (EHR). R40’s discharge summary and recapitulation of stay was requested 7/29/25 and provided 7/30/29. The discharge summary progress note dated 7/18/25 12:37 p.m., noted as “late entry” indicated the director of nursing (DON) created the entry on 7/29/25 at 8:52 p.m., and noted resident left AMA and both resident and daughter were made aware by SS-A, facility would not be responsible to arrange home services. During interview on 7/31/25 at 3:30 p.m., registered nurse (RN)-A, case manager, stated discharge planning is discussed during the care conference. During the discharge process the discharge assessment was completed in the computer, this was reviewed and signed with the resident upon completion. If the resident was going home, they also reviewed the discharge instructions. RN-A stated for a resident who voiced intent to leave the facility AMA they would get ahold of the family and resident and ensure they understood and wanted to proceed. RN-A stated they would have filed a MAARC if the discharge was unsafe. RN-A stated when discharging AMA SS-A completed the paperwork, and entered the discharge progress note which included the		F0628				

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F0628 SS = D	Continued from page 15 recapitulation of stay. RN-A stated R40 had planned to discharge to the AL facility, her daughter had called and spoke to the business office, daughter had stated she was on her way to the facility, while there she voiced financial concerns, staff from the AL came over to speak with them and explain options available, and they still decided R40 would discharge home with her daughter. RN-A stated R40 and daughter were informed facility is not responsible when discharging AMA. During interview on 7/31/25 at 3:35 p.m., DON confirmed she did go back into R40's EHR and enter a discharge summary after requested by surveyor, as it had been missed. DON stated daughter had contacted facility when they were out of facility, DON stated SS-A completed AMA form with R40 while R40 was in a vehicle. DON stated when discharging a resident, they usually gave a summary to the resident that included: medications, recent labs, and follow up appointments. DON stated R40's daughter made it "very clear" that they would follow up with their own provider and "not to worry about it". During interview on 8/01/25 at 11:38 a.m., director of operations (DOO) stated if they were made aware of resident's intent to discharge AMA, SS-A would meet with the resident and provide education as well as inform of risks. SS-A would also encourage resident to see their primary care provider, as the facility was unable to provide additional services or arrangements for services outside of the facility such as home care. DOO stated medical provider was notified of the AMA discharge. There should have been some sort of documentation, "normal things" but they were not required to provide much info, and no medication information was provided for AMA discharges. Facility discharge policy requested and not received.		F0628				
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and		F0656	09/04/2025		09/04/2025	
				1. Sterling Park Healthcare Center corrected the deficiency by developing a person center care plan for R25 by 9/4/2025 and auditing all other resident care plans to ensure they are person centered by 9/4/2025.			
				2. To correct the deficiency and to ensure the problem does not recur all nursing leadership staff were educated by 9/4/2025 on the facility expectations for			

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F0656 SS = D	Continued from page 16 psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to develop a person-centered care plan for 1 of 2 residents (R25) reviewed for care planning. Findings include: R25's annual Minimum Data Set (MDS) dated 7/21/25,			F0656	Continued from page 16 person centered care planning by ED/DON. The DON and/or designee will audit 2 random resident care plans weekly for 4 weeks to ensure they are person centered. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F0656 SS = D	Continued from page 17 identified R25 had intact cognition and required moderate assistance with activities of daily living (ADL)'s. R25's diagnoses included acute respiratory failure with hypoxia, atrial fibrillation, hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperkalemia, depression, respiratory failure, obstructive sleep apnea, and mild cognitive impairment of uncertain or unknown etiology. R35's care plan included: · "(Preferred Name) has an ADL Self Care Performance Deficit r/t (related to)..." dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has (SPECIFY: Diabetes Mellitus, hyperglycemia, hypoglycemia)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has altered cardiovascular status R/T (SPECIFYCARDIAC DX) (SPECIFY: With / without potential for bleeding/bruising R/T aspirin use, anticoagulant therapy, Lovenox, heparin, Plavix)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has an alteration in hematological status R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) uses Antidepressant Medication due to (SPECIFY: feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping) R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has actual/potential for (SPECIFY: Chronic, Acute, Neuropathic) Pain with need for medication management R/T (SPECIFY)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) is considered a vulnerable adult R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has altered respiratory status/difficulty breathing (SPECIFY: shortness of		F0656				

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F0656 SS = D	Continued from page 18 breath) R/T (SPECIFY: Requires oxygen therapy)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) wishes to return to the community (SPECIFY: goals for admission and desired outcome)” dated 5/16/25 and lacked goals and interventions. R25's physician orders included amlodipine and metoprolol for hypertension; Xarelto for atrial fibrillation; duloxetine for depression and anxiety; menthol-methyl salicylate cream, acetaminophen, pregabalin and tramadol for pain; and Baqsimi, Lantus and Mounjaro insulin injections for diabetes. During interview on 8/1/25 at 11:37 a.m. director of nursing (DON) and registered nurse clinical coordinators (RN)-A and RN-B stated the MDS coordinator was responsible for entering and revising resident care plans and that she left the facility in February 2025. DON confirmed R25's was not completed nor individualized. DON stated person-centered care plans are important, so staff are aware of how to care for the resident and that the care is individualized. The facility Comprehensive Care Plan policy, dated 4/25, indicated facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.		F0656				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:		F0684	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by educating all nursing staff on ensuring R21 and all like residents have wheelchair pedals in place while being pushed via wheelchair by 9/4/2025. A medication error risk management was completed for R25 and all like residents with orders for medication with vital parameters were reviewed for errors by 9/4/2025. 2. To correct the deficiency and to ensure the problem does not recur wheelchair pedal bags were ordered for all residents that use wheelchairs by 9/4/2025. All nursing staff were educated by 9/4/2025 on the facility		09/04/2025	

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F0684 SS = D	Continued from page 19 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 1 of 1 resident (R21) reviewed for wheelchair usage. Further, the facility failed to ensure medications were administered per physician's order for 1 of 1 resident (R25) reviewed for assessment prior to medication administration. Findings include: R21 R21's annual Minimum Data Set (MDS) dated 6/10/25, identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. R21's care plan identified R21 had a self-care deficit and required assistance with transfers and locomotion in a wheelchair to reach desired destinations and utilized a wheelchair. Care plan also indicated on 7/21/25 R21 received hard back and seat custom wheelchair with foot pedals. During observation on 7/28/25 at 11:34 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor approximately four times. Staff did not provide reminders to R21 to hold her feet up. During observation and interview on 7/28/25 at 1:55 p.m., R21's foot pedals for her wheelchair were sitting in a basket that was placed on the left side of her recliner up against the wall. R21 stated staff assist her to the dining room for all meals. She had foot pedals for her wheelchair but were only used when she goes out to an appointment. R21 stated it was "sometimes" hard to keep her feet up when staff are pushing her down the hallway in her wheelchair.			F0684	Continued from page 19 procedure for medication administration with vital parameters by ED/DON. The DON and/or designee will audit 2 random residents for medication administration weekly for 4 weeks to ensure compliance. The DON and/or designee will audit 2 random residents for proper wheelchair pedal use while being escorted by staff weekly for 4 weeks to ensure compliance. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F0684 SS = D	Continued from page 20 During observation on 7/30/25 at 11:41 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding and bouncing on floor. Staff did not provide reminders to R21 to hold her feet up. During observation on 7/30/25 at 12:31 p.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor approximately four times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During observation on 7/31/25 at 7:42 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. Foot pedals were attached to wheelchair but were folded up and pushed under the seat of the wheelchair. R21's feet were sliding on floor and feet bounced off the floor approximately three times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During observation on 7/31/25 at 8:24 a.m., R21 was assisted out of the dining room and was brought to the medication cart with her feet sliding on floor. During observation on 7/31/25 at 8:24 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor several times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During interview on 07/31/25 at 3:22 p.m., licensed practical nurse (LPN)-A stated foot pedals are used when the resident is not about to pick up their feet or needed assistant with keeping their feet off the floor. LPN-A stated foot pedals should be used for residents who are not able to keep their feet up when staff pushed the wheelchair to and from destinations. LPN-A stated R21 should use foot pedals when staff are assisting her in her wheelchair to and from destinations. LPN-A stated it was important for foot pedals to be used for safety when escorting residents in a wheelchair to and from destinations and to prevent injuries.		F0684				

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F0684 SS = D	Continued from page 21 During interview on 8/1/25 at 10:39 a.m., nursing assistant (NA)-A stated foot pedals are used as needed. NA-B stated R21 has foot pedals that should be used if staff are assisting her with propelling wheelchair. NA-A stated R21 does not use foot pedals often. During interview on 8/1/25 at 10:46 a.m., trained medication aide (TMA)-B stated foot pedals should be used for any resident who had them and needed staff assistance transporting to and from any destination. TMA-A stated R21 does have foot pedals. During interview on 8/1/25 at 11:32 a.m., director of nursing (DON) stated foot pedals are not always on the wheelchair but are stored in resident's room to be used as needed. When a resident was exhibiting signs of not being able to keep feet held off floor when being transported to and from destinations, DON expected foot pedals be placed on wheelchair and used. She expected staff to use foot pedals in all observations noted above. DON stated it was important to use foot pedals on wheelchair during transport to prevent injury and that it was best practice. A wheelchair positioning policy was requested but was not provided. R25 R25's annual MDS dated 7/21/25, identified R25 had intact cognition and required moderate assistance with ADL's. R25's diagnoses included acute respiratory failure with hypoxia, atrial fibrillation, hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperkalemia, depression, respiratory failure, obstructive sleep apnea, and mild cognitive impairment of uncertain or unknown etiology. During review of R25's electronic health record (EHR), signed physician's orders, print date of 7/30/25, indicated an order for the following medications with parameters for when medication should be held: · Metoprolol Tartrate 100 mg (milligram) to be given by mouth two times a day for essential hypertension and to hold for heart rate less than 5 and systolic blood pressure less than 90.		F0684				

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F0684 SS = D	Continued from page 22 · Amlodipine Besylate 10 mg to be given by mouth once daily in the morning for type II diabetes mellitus with diabetic polyneuropathy and to hold for heart rate less than 5 and systolic blood pressure less than 90. · Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed from 6/1/25 to 8/1/25, lacked documentation of obtaining and monitoring blood pressure and pulse prior to administration of medication from 6/1/25 to 8/1/25. Instructions with parameters were noted on the MAR. During interview on 8/1/25 at 10:53 a.m., TMA-B stated R25 had special monitoring for medication administration. TMA-B confirmed R25 should have blood pressure and pulse checked prior to administration of Metoprolol and Amlodipine. TMA-B stated she was aware of the parameters and stated she takes R25's blood pressure or pulse, prior to administering metoprolol to R25, and documented the results in the EHR. During interview on 8/1/25 at 11:16 a.m., TMA-A stated R25 should have blood pressure checked prior to administration of his Metoprolol and Amlodipine. If the blood pressure is too low, then the Metoprolol and Amlodipine were held. TMA-A stated she documented the blood pressure in the HER when she obtained it. During interview on 8/1/25 at 11:20 a.m., DON stated she expected provider's orders to be followed, including parameters of medication administration. DON confirmed R25's blood pressure and pulse should have been obtained prior to administration of the Metoprolol and Amlodipine. DON stated following these parameters were important as it was an order from the provider and so the resident does not have any bad outcomes of the medication if it was administered when it was not supposed to be. On 8/1/25 at 11:05 a.m., Attempted to reach out to consultant pharmacist and left message with no return call back. A Medication Management – Medication Administration policy, dated 4/16/24, indicated staff were to obtain and record any vital signs as necessary prior to		F0684				

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F0684 SS = D	Continued from page 23 medication administration.			F0684			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a resident for safe electric recliner usage for 1 of 1 resident (R21) reviewed for accidents. Findings include: R21's annual Minimum Data Set (MDS) dated 6/10/25, identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. R21's care plan, print date of 7/31/25, indicated staff were to encourage R21 to elevate legs in recliner. R21's care plan reviewed 7/31/25, identified R21 had limited physical mobility with fall risk related to weakness and limited mobility and had no recent history of falls. Care plan indicated R21 was non-ambulatory and needed assistance from two staff for bed mobility and transfers. During review of R21's electronic health record (EHR), Physical Device assessment completed on 6/9/25 indicated R21 utilized grab bars that were on bed and a wheelchair. Physical device assessment did not identify			F0689	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by assessing R21 for safe electric recliner use by 9/4/2025. All like residents with an electric recliner were assessed for safe use by 9/4/2025. 2. To correct the deficiency and to ensure the problem does not recur all nursing leadership staff were educated by 9/4/2025 on the physical device assessment expectations by ED/DON. The DON and/or designee will audit 2 random residents weekly for 4 weeks to ensure they have been assessed for electric recliner use. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/04/2025

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F0689 SS = D	Continued from page 24 the electric recliner was assessed or utilized by R21. During observation and interview on 7/28/25 at 1:43 p.m., R21 was sitting in her electric recliner in her room with her legs elevated. R21 stated she was able to control the remote for the electric recliner and reached for the remote to demonstrate. R21 started to push buttons on the remote and then stopped and put the remote on the arm of the recliner. During observation on 7/28/25 at 1:55 p.m., staff rushed into R21's room as R21 had gotten her electric recliner elevated all the way up and was about to slide to the floor. Staff intervened and safely lowered the recliner without further incident. During interview on 7/28/25 at 1:58 p.m., nursing assistant (NA)-C confirmed R21 had gotten electric recliner raised up, so R21 almost slid out of the recliner onto the floor. During observation on 7/30/25 at 9:49 a.m., R21 was sitting in her electric recliner in her room with her legs elevated. Electric recliner remote was within R21's reach. During observation on 7/30/25 at 3:50 p.m., R21 was sitting in her electric recliner in her room with her feet placed on the floor. Electric recliner remote was within R21's reach. During interview on 8/1/25 at 10:39 a.m., NA-A stated R21 could not function the remote on the electric recliner and had confusion occasionally on what she is supposed to do or be doing. NA-A stated R21 sat in her recliner in the morning after breakfast with her legs elevated to help with swelling in her legs. During interview on 8/1/25 at 10:46 a.m., NA-B stated R21 does not usually attempt to get out of her recliner. NA-B stated R21 can function the remote of the electric recliner and uses the remote all the time. During interview on 8/1/25 at 11:15 a.m., trained medication aide (TMA)-A stated R21 will play/fidget with the remote of her electric recliner.		F0689				

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F0689 SS = D	Continued from page 25 During interview on 8/1/25 at 11:32 a.m., registered nurse clinical coordinator (RN)-A, registered nurse clinical coordinator (RN)-B and director of nursing (DON) stated R21 needed assistance to get out of chair, was a fall risk and confirmed R21 utilized the electric recliner in her room. Stated electric recliner should be assessed through the physical device assessment and should be assessed quarterly or with a change in condition. DON confirmed electric recliner was not assessed or mentioned on the physical device assessment and should have been. DON stated it was important for the electric recliner to be assessed to ensure the resident can use the recliner safely. An assistive device and assessment of physical devices policies were requested but was not received.		F0689				
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.		F0727	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by educating all leadership nurses and the facility staffing coordinator by 9/4/2025 of facility requirement for 8 consecutive hours per day of RN coverage. 2. To ensure the problem does not recur the DON and/or designee will audit the schedule two times per week for 4 weeks to ensure 8 consecutive hours per day of RN coverage. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		09/04/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/01/2025	
NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 56387			
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F0727 SS = F	Continued from page 26 §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that a Registered Nurse (RN) was on-site for at least 8 consecutive hours on a daily basis. Lack of consistent RN coverage may result in delayed assessment, clinical decision-making, or care interventions, potentially jeopardizing resident health and safety. This failure had the potential to negatively impact resident care and oversight. Findings include: Facility payroll based journal (PBJ) staffing data report for fiscal year 2025, quarter 2 (January 1- March 31) triggered excessively low weekend staffing. Facility Assessment dated 3/24/25- indicated facility need for 1 RN for 40 residents. Facility staffing schedules indicated RNs were scheduled for 12-hour shifts (6am-6:30pm, and 6pm-6:30am). Review of facility staffing data submitted for PBJ report, for weekends 1/1/25-3/31/25, revealed no RN coverage for Sunday 2/23/25. During interview on 7/30/25 at 2:39 p.m., director of operations (DOO) stated the facility had a contingency plan in place for RN coverage. If the need did not meet the level to activate that plan, they would mandate overtime and activate their call tree to the director of nursing (DON) and DOO for emergency staffing needs, which included calling in qualified leadership team members, as needed (PRN) and agency staff. During interview on 7/31/25 at 8:18 a.m., staffing coordinator (SC) stated on weekends the nurse in charge would contact SC and DON if nursing staff called in. DON and SC then would look for someone to cover the open shift. DON used OnShift app (an application used		F0727				

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F0727 SS = F	Continued from page 27 to post open shifts) to post the open shift. SC stated if facility did not have a RN in the building, they would have one come in. The DON and RN case managers had an on-call rotation and were expected to come in if needed. SC stated she was trained the facility was allowed a maximum of three days per quarter with no RN coverage, but the goal was to have zero days, and to avoid using days. The facility had four PRN nurses. SC stated the facility utilized a block schedule rotation which auto populated into the monthly calendar, she then reviewed the vacation time to determine open shifts needing to be filled. The monthly schedule was published by the second week of the previous month. During interview on 7/31/25 at 1:37 p.m., human resources (HR) stated they used OnShift for scheduling and time keeping which was reviewed by the corporate HR consultant and leadership team. HR facilitated newly hired personnel, which included full-time, part-time, and PRN. HR confirmed they used a rotating two-week block schedule and strived for zero days with no RN coverage. During interview on 7/31/25 at 1:51 p.m., DOO stated when staff called in, they required a minimum of two hours prior to their scheduled shift, the charge nurse filled out a call off slip for tracking. They had contracts with agencies, and an RN on-call rotation to ensure RN coverage. DOO expected the nurse on-call to address the need accordingly. DOO stated her expectation for the on-call nurse on the weekend, was to be within one hour of the facility and able to come in if needed, at any time. During follow-up interview on 7/31/25 at 2:30 p.m., DOO explained on 2/23/25 there had been an open RN shift posted to OnShift, which had been picked up by a licensed practical nurse (LPN). DOO believed SC had accepted, and this had not been recognized as an error.		F0727				
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.		F0880	09/04/2025 1. Sterling Park Healthcare Center corrected the deficiency by educating R25 on proper infection control techniques on 8/1/2025. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff & dietary staff were educated by 9/4/2025 on the infection control policy		09/04/2025	

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F0880 SS = D	Continued from page 28 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.		F0880	Continued from page 28 and procedure and expectations related to resident supervision and dining services by ED/DON. The DON and/or designee will audit 4 meal services weekly for 4 weeks to ensure proper infection control processes occur. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.			

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F0880 SS = D	Continued from page 29 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices during meal service for 3 of 3 dining observations. Specifically, staff failed to intervene when a resident (R25) was observed touching the tops of other residents' coffee cups during meal service, creating a risk for cross-contamination and transmission of communicable diseases. Findings include: During observation on 7/28/25 at 11:38 a.m., during a lunch observation in the main dining room, R25 was observed walking around the dining room and stopping at multiple tables. R25 was observed touching the tops/rimms of coffee cups, that were placed on the seat of his walker, when handing them out to other residents. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During observation on 7/30/25 at 11:39 a.m., during a lunch observation in the main dining room, R25 was observed walking around the dining room and stopping at multiple tables to pick up coffee cups. R25 was observed touching the tops/rimms of coffee cups when handing them out to other residents. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During observation on 7/31/25 at 8:06 a.m., during a		F0880				

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F0880 SS = D	Continued from page 30 breakfast observation in the main dining room, R25 was observed walking to a co-resident and asking if she would like more coffee. Co-resident was holding onto handle of coffee cup and handed it to R25 who gripped the coffee cup around the top/rim of coffee cup. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During interview on 8/1/25 at 10:53 a.m., nursing assistant (NA)-B stated R25 liked to get coffee for other residents in the dining room and did so at every meal. During interview on 7/31/25 at 3:37 p.m., Infection Preventionist (IP) acknowledged that residents should not be touching the food or drink items of others, and staff should intervene to prevent such contact to avoid possible transmission of infectious agents. The IP further stated that this behavior was not in accordance with the facility's infection control protocols. A copy of the facility's Infection Prevention and Control policy related to dining services was requested on 8/1/25 but was not received by the time of the survey.		F0880				

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET , WAITE PARK, Minnesota, 56387			
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 29, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Sterling Park Health Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			09/03/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Sterling Park Healthcare Center is a 1 story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963, that was determined to be of Type II(000) construction. In 1983, an addition was added to the dining room that was determined to be of Type II(000) construction. In 2003 an addition was added to the east that was determined to be of Type II(111) construction. In 2010 a enclosed courtyard addition was add that was determined to be of Type II(111) construction. The facility has a capacity of 40 beds and had a census of 23 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0712 SS = F Bldg 01	Fire Drills CFR(s): NFPA 101		K0712	09/04/2025		09/04/2025	

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K0712 SS = F Bldg. 01	Continued from page 2 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per 42 CFR 483.470(i). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/29/2025, at 9:10 AM, it was revealed by a review of available documentation that at the fire drills exceeded the quarterly requirement leaving 4 months between drills for all three shifts.. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712	Continued from page 2 1. Sterling Park Healthcare Center corrected the deficiency by educating all maintenance staff on the updated fire drill schedule on 7/29/2025. 2. To correct the deficiency and to ensure the problem does not recur the ED and/or designee will audit all fire drills monthly for 3 months to ensure compliance with new schedule. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 20, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: REY711

Dear Administrator:

The above facility survey was completed on August 1, 2025 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, slightly slanted style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/01/2025	
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20000	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 7/28/25 to 8/1/25, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.			20000			08/28/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: NO licensing orders were issued. H53759948C (MN00103391) H53759875C (MN00106092) H53759876C (MN00108135) H53759947C (MN00110943) HL241021080C 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 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 evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.		20000				
20505	Use of Restraints		20505	completed		09/04/2025	

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20505	Continued from page 2 CFR(s): MN Rule 4658.0300 Subp. 1 A-E Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure parameter mattress (a type of mattress cover, or encasement designed to create a gentle barrier around the edge of the bed, preventing falls) was not used in a manner to restrain		20505				

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20505	Continued from page 3 resident while in bed for 1 of 1 resident (R21) reviewed for restraints. Findings include: R21's annual Minimum Data Set (MDS) dated 6/10/25, identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. MDS did not indicate R21 utilized restraints. R21's care plan reviewed 7/31/25, identified R21 had limited physical mobility with fall risk related to weakness and limited mobility and had no recent history of falls. Care plan indicated R21 had a lipped mattress initiated on 6/21/23, to decrease the risk of falls when sitting on edge of bed and low bed to limit injuries from falls. Care plan indicated R21 was non-ambulatory and needed assistance from two staff for bed mobility and transfers. During review of R21's electronic health record (EHR), Physical Device assessment completed on 6/9/25 indicated R21 utilized grab bars that were on bed and a wheelchair. Physical device assessment did not identify the parameter mattress was assessed or utilized by R21. During observation and interview on 7/28/25 at 1:48 p.m., R21's bed had a parameter mattress in place. R21 stated she was not sure why she had the parameter mattress on the bed and she does not attempt to get out of bed by herself as she knows she is not strong enough and she waits for staff for assistance. During interview on 7/31/25 at 3:22 p.m., licensed practical nurse (LPN)-A confirmed R21 had a parameter mattress present on bed. LPN-A stated R21 was not able to get out of bed by herself and has not tried to get out of bed by herself for some time. During interview on 8/1/25 at 10:39 a.m., nursing assistant (NA)-A stated R21 had a parameter mattress in		20505				

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20505	Continued from page 4 place that has been there for several years to assist R21 with not falling out of bed. NA-A stated R21 was not able to reposition herself and was not able to get out of bed by herself for approximately the past year. During interview on 8/1/25 at 10:46 a.m., NA-B stated R21 had a parameter mattress present to assist R21 with not falling out of bed. NA-B stated R21 no longer attempts to get out of her bed independently and has not for quite a while. During interview on 8/1/25 at 11:32 a.m., registered nurse clinical coordinator (RN)-A, registered nurse clinical coordinator (RN)-B and director of nursing (DON) stated R21 needed assistance to get out of bed, was a fall risk and confirmed R21 had a parameter mattress in place. Parameter mattresses were assessed through the physical device assessment and should be assessed quarterly or with a change in condition. DON stated parameter mattresses helped resident identify the edge of the bed. The mattress could be considered a restraint when it was used to prevent the resident from getting out of bed or if resident was immobile. DON confirmed R21's parameter mattress was not assessed or mentioned on the physical device assessment and should have been. RN-A, RN-B and DON stated they are not sure why R21 still had the parameter mattress in place. The facility Restraint Free Environment policy, dated 2/23/25, indicated it was the policy of the facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. “Physical Restraint” refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot be removed easily which restricts freedom of movement or normal access to one’s body. Physical restraints may include but are not limited to placing a resident on a concave mattress so that the resident cannot independently get out of bed. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident’s medical symptoms. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment		20505				

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20505	Continued from page 5 that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality and Assessment Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20505				
20560	Comprehensive Plan of Care; Contents CFR(s): MN Rule 4658.0405 Subp. 2 Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to develop a person-centered care plan for 1 of 2 residents (R25) reviewed for care planning. Findings include: R25's annual Minimum Data Set (MDS) dated 7/21/25, identified R25 had intact cognition and required moderate assistance with activities of daily living (ADL)'s. R25's diagnoses included acute respiratory failure with hypoxia, atrial fibrillation, hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperkalemia, depression, respiratory failure, obstructive sleep apnea, and mild cognitive impairment of uncertain or unknown etiology. R35's care plan included:		20560	completed		09/04/2025	

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20560	Continued from page 6 · "(Preferred Name) has an ADL Self Care Performance Deficit r/t (related to)..." dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has (SPECIFY: Diabetes Mellitus, hyperglycemia, hypoglycemia)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has altered cardiovascular status R/T (SPECIFYCARDIAC DX) (SPECIFY: With / without potential for bleeding/bruising R/T aspirin use, anticoagulant therapy, Lovenox, heparin, Plavix)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has an alteration in hematological status R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) uses Antidepressant Medication due to (SPECIFY: feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping) R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has actual/potential for (SPECIFY: Chronic, Acute, Neuropathic) Pain with need for medication management R/T (SPECIFY)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) is considered a vulnerable adult R/T” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) has altered respiratory status/difficulty breathing (SPECIFY: shortness of breath) R/T (SPECIFY: Requires oxygen therapy)” dated 5/16/25 and lacked goals and interventions. · “(Preferred Name) wishes to return to the community (SPECIFY: goals for admission and desired outcome)” dated 5/16/25 and lacked goals and interventions. R25's physician orders included amlodipine and metoprolol for hypertension; Xarelto for atrial	20560					

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20560	Continued from page 7 fibrillation; duloxetine for depression and anxiety; menthol-methyl salicylate cream, acetaminophen, pregabalin and tramadol for pain; and Baqsimi, Lantus and Mounjaro insulin injections for diabetes. During interview on 8/1/25 at 11:37 a.m. director of nursing (DON) and registered nurse clinical coordinators (RN)-A and RN-B stated the MDS coordinator was responsible for entering and revising resident care plans and that she left the facility in February 2025. DON confirmed R25's was not completed nor individualized. DON stated person-centered care plans are important, so staff are aware of how to care for the resident and that the care is individualized. The facility Comprehensive Care Plan policy, dated 4/25, indicated facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure timely evaluation and care planning for identified problem areas; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		20560				
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.		21830	corrected		09/04/2025	

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21830	Continued from page 8 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social		21830				

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21830	Continued from page 9 service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow process to ensure advanced directives were accurately documented and updated on the resident's electronic health record (EHR) banner, physician orders and Physician's Orders for Life Saving Treatment (POLST) which affected 2 of 16 residents (R35 and R19) reviewed for advance directives. These findings constituted an immediate jeopardy (IJ) situation for R35 and R19 who would not have received cardiopulmonary resuscitation measures (CPR) according to their wishes. The IJ began on 11/26/24, when R35's POLST, indicating R35's wishes for resuscitation was signed by the medical provider and it was not changed within the facility's EHR to reflect R35's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care staff outlined they would implement the incorrect directions and not perform CPR which was against R35's wishes due to this error. The director of nursing (DON) was notified of the IJ on 7/28/25 at 5:55 p.m. The IJ was removed on 7/29/25 at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. The director of nursing (DON) was notified of the IJ on 7/28/25 at 5:55 p.m. The IJ was removed on 7/29/25 at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R35's quarterly Minimum Data Set (MDS) dated 5/1/25, identified R35 had intact cognition and required		21830				

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21830	Continued from page 10 assistance with all activities of daily living (ADL)'s. R35's diagnoses included acute on chronic systolic (congestive) heart failure, hypertension, renal failure, diabetes mellitus, and chronic respiratory failure with hypoxia. R35's electronic health record (EHR) banner reviewed on 7/28/25 at 4:18 p.m., identified R35 was do not resuscitate/do not intubate (DNR/DNI). R35's Order Summary report dated 7/28/25, indicated DNR/DNI status. R35's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse's station, signed by R35 and medical doctor (MD)-A on 11/26/24 indicated full code status. During interview on 7/28/25 at 3:02 p.m., trained medication aide (TMA)-A stated she would refer to the banner in the EHR, in the event of an emergency, regarding resident's code status. TMA-A confirmed R35's code status stated DNR/DNI. TMA-A stated they would take no action, except to notify the nurse, in the event R35 was without breath or heartbeat. According to information noted in R35's EHR, TMA-A stated they would alert the nurse R35 was do not resuscitate/do not intubate. During interview on 7/28/25 at 3:04 p.m., nursing assistant (NA)-A stated she would refer to the banner on the computer or tablet regarding resident's code status. During interview on 7/28/25 at 4:29 p.m., R35 stated if her heart stopped, she would want cardiopulmonary resuscitation (CPR) to resuscitate her. During interview on 7/28/25 at 4:31 p.m., director of nursing (DON) stated her expectations would be for staff to look at the emergency red binder located in the nurse's station in the event of an emergency at the actual signed POLST for code status. If code status orders do not match, there would be a high risk of initiating the wrong life-saving treatments. DON looked at POLST that was in the emergency red binder and confirmed code status was changed to full code on 11/26/24 and was signed by both R35 and the provider. DON then confirmed the banner and order in the EHR		21830				

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21830	Continued from page 11 stated code status as DNR/DNI and the order date on it was 7/20/23. DON confirmed the providers order from 11/26/24 had gotten missed and that R35 would not have received CPR in the event of an emergency. R19's R19's admission Minimum Data Set (MDS) dated 6/6/25, identified R19 had intact cognition and required assistance with all activities of daily living (ADL)'s. R19's diagnoses included type II diabetes mellitus (DM) with polyneuropathy, hypothyroidism, hypertension, and chronic kidney disease stage 3. R19's electronic health record (EHR) banner reviewed on 7/28/25 at 3:20 p.m., identified R19 was do not resuscitate (DNR). R19's Order Summary report dated 7/28/25, indicated DNR status. R19's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse's station, signed by R19 on 5/21/25 indicated full code status. R19's Directives to Define Scope of Medical Care form, signed by R19 and dated 5/21/25, indicated TO RESUSCITATE. Both forms were signed by certified nurse practitioner (CNP)-A on 5/22/25 and were scanned into R19's EHR. During interview on 7/28/25 at 3:00 p.m., R19 stated she wanted cardiopulmonary resuscitation (CPR) to be performed if necessary, but she did not "want all the tubes and stuff". During interview on 7/28/25 at 3:03 p.m., licensed practical nurse (LPN)-B stated she would refer to the banner in the EHR, in the event of an emergency. If she did not have access, she would look in the binder kept in the nurses charting room. LPN-B accessed PCC and confirmed R19's banner indicated DNR. LPN-B stated if there was a discrepancy she would call the residents family member or power of attorney if they had one to determine the residents wishes. LPN-B stated, if R19's heart stopped or R19 stopped breathing, she would not initiated CPR as directions in PCC were DNR. During interview on 7/28/25 at 3:57 p.m., Director of Nursing (DON) stated during the admission process they completed an initial form named Directives to Define		21830				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/01/2025	
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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	
21830	Continued from page 12 Scope of Medical Care, indicating the residents wishes and code status. That form was temporary, until the medical provider comes in and the completes the POLST form with the resident and/or Power of Attorney (POA). Once the POLST was completed it was scanned into the EHR and then placed in the red binders at the nurse's station. The Case Manager was responsible for obtaining orders signed by the medical provider and entering the order into the residents EHR which pulled into the banner. DON stated if there were a discrepancy the care staff know to use the POLST/binder. DON stated she felt the orders should be double checked by another nurse. DON stated CNP-A was usually good about telling them if there was a change, and the residents code status was also supposed to be reviewed with the resident and/or family during care conferences quarterly and annually and this was handled by the social worker. DON stated her expectation in the event of a medical emergency, was for staff to go directly to the red POLST binder, rather than trying to log in to the EHR. If there were a discrepancy there would not have been time to call a POA for clarification. DON stated if they found a discrepancy while performing chart audits, they would have followed up with the resident/POA to determine their wishes and then make sure it is reflected in the banner and the POLST. During interview on 7/28/25 at 4:30 p.m., social services (SS)-A stated she pulled the code status off the EHR and checked the advanced directives documents such as POLST, to verify accuracy as well as any POA or legal guardianship paperwork when she prepared for resident's care conferences. SS-A stated she verbalized the current code status, and asked the resident and/or POA if that is still their wishes. If resident or POA had not agreed, she would have corrected this with them. During interview on 7/29/25 at 10:51 a.m., trained medication aide (TMA)-C- stated she recently received education regarding resident POLST's. TMA-C stated in the event of a medical emergency, she would look in the red binder, which is alphabetized by residents last name, to locate the necessary residents' POLST. TMA-C stated the training entailed reading the information provided, followed by a verbal quiz on the information. During interview on 7/29/25 at 10:55 a.m., nursing assistant (NA)-D stated he received training last night about CPR and code statuses. He stated they are to look in the red binders at the nurses' station. NA-D stated		21830				

Minnesota State Department of Health

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21830	Continued from page 13 he was told how he was to determine code status, and that the nurse was to make the call. In the event of an emergency someone checked the POLST kept at the nurses' station in two red binders filed alphabetically. NA-D stated the DON spoke with him and signed off on his retraining. The facility policy Cardiopulmonary Resuscitation (CPR) dated 4/21/25, identified it was the policy of the facility to adhere to resident's rights to formulate advance directives. Advance Directives to define the scope of medical care will be discussed with the potential resident and/or resident representatives at the time of admission. The facility will review decisions about a resident's CPR status at each initial care conference, at quarterly care conferences, at resident and/or resident representative request as well as at the time of any permanent, significant change in the resident's status that results in the development of a new care plan. The IJ was removed on 7/29/25 at 10:56 a.m., when the facility developed and implemented a systematic removal plan which was verified by interview and document review. On 7/28/25, the facility completed an audit of all residents' code status, reviewed the process to ensure the entered POLST information into the EMR was accurate and updated. On 7/28/25 licensed staff were educated regarding the updated POLST procedure and where to find a residents' code status. and continued for staff prior to their next shift. During interview on 8/1/25 at 11:45 a.m., director of operations (DOO) stated the facility did not have an advance directive policy. DOO stated the POLST should have been processed and entered in the EHR as any other provider order. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21830				