

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered June 14, 2021

Administrator Sterling Park Health Care Center 142 North First Street Waite Park, MN 56387

RE: CCN: 245375 Cycle Start Date: April 26, 2021

Dear Administrator:

On May 27, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 7, 2021

Administrator Sterling Park Health Care Center 142 North First Street Waite Park, MN 56387

RE: CCN: 245375 Cycle Start Date: April 26, 2021

Dear Administrator:

On April 26, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

Sterling Park Health Care Center May 7, 2021 Page 2

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor St. Cloud B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us Office: (320) 223-7343 Mobile: (320) 290-1155

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 26, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

Sterling Park Health Care Center May 7, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by October 26, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. Feel free to contact me if you have questions.

Sincerely,

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	TE SURVEY MPLETED
		245375	B. WING _			C / 26/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2021
STERLIN	IG PARK HEALTH CA	RE CENTER		142 NORTH FIRST STREET WAITE PARK, MN 56387		
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F 000	INITIAL COMMENT	ſS	F 00	00		
	conducted at your f to be NOT in comp	dard abbreviated survey was acility. Your facility was found liance with the requirements of art B, Requirements for Long s.				
	SUBSTANTIATED:	laints were found to be 2133), with a deficiency cited				
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 689 SS=D	onsite revisit of you validate that substa regulations has bee Free of Accident Ha	azards/Supervision/Devices	F 68	89		5/24/21
	supervision and ass accidents. This REQUIREMEN by:	resident receives adequate sistance devices to prevent NT is not met as evidenced				
	Dased on Interview	<i>i</i> and document review, the		F (F689)		
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	_	(X6) DATE 05/17/2021

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

PRINTED: 05/20/2021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMF	PLETED
245375 B. WING		_ 26/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
STERLING PARK HEALTH CARE CENTER 142 NORTH FIRST STREET WAITE PARK, MN 56387		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
 F 689 Continued From page 1 facility failed to comprehensively assess and develop interventions to provide adequate safety after a resident to resident verbal altercation for 2 of 3 residents reviewed (R1, R2), which resulted in a fall and in addition, a subsequent resident to resident physical altercation which had the potential to result in an additional fall. Findings include: R1's quarterly minimal data set (MDS) dated 1/25/21, indicated R1 had diagnoses that included dementia and Parkinson's disease. Further review of MDS, indicated R1 did not display behaviors and has had one fall with injury. R1's progress note dated 4/16/21, indicated R1 "was involved in a verbal altercation with another resident after dinner. Confusion over who was in control and possession of TV [television] remote. [R1] was instructed to inform staff, cannot walk over to another resident and atterngt to remove item. Other resident and atterngt to remove item. Other resident and atterf. TV." Further review of R1's progress notes and staff immediately separated R1 and R2. R1's Progress notes reviewed from 4/16/21. R1's Progress notes reviewed from 4/16/21. R1's care plan printed 4/26/21, indicated R1 was at risk for falls related to end stage Parkinson's with shuffled gait, dementia with poor safety awareness, and history of falls. Further review of care plan, indicated R1's care place lacked 	gulations. tion does agreement of the t forth in The plan of executed the law. for s and tly rrective facility th the r that y. th I residents cident eive stance to k e R2 have revent cations or evention resident the facility past 30 rventions	

Facility ID: 00643

If continuation sheet Page 2 of 6

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375 RE CENTER				E SURVEY PLETED	
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Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
rere not added to prevent njury. dated 4/16/21, indicated R2 ing a verbal altercation with 1]. Writer observed resident grab the remote control away R2 would not let go off [of] the asked both resident[s] to stop remote, R2 left the remote. As esident [R1] lost his balance buttock. Staff immediately, residents. R2 was directed to the other TV to watch his tled for rest of shift." over 341538 dated 4/21/21, ratching TV in the dayroom over to R2 and began to argue mote control for the TV. R1 ve the controller from R2's on the head. Nursing rervened and "caught" R1 "with rould not fall". 4/26/21, at 11:09 a.m. R1 R2] pushed each other. I ped over someone's foot and 4/26/21, at 12:20 p.m. NA-A nt happened on 4/21/21, "right R1 stood up and started	F 68	 the problem does not recur all r staff will be reeducated on the f accident/incident policy includin and documentation by the DON designee. The DON and/or des audit all incidents weekly for 4 v then randomly ongoing. Comp 5/24/2021. 3. As part of Sterling Park Heal Center ongoing commitment to assurance, the DON and/or ED 	acility g reporting l and/or ignee will veeks and eted by thcare quality		
	dated 4/16/21, indicated R2 ing a verbal altercation with 1]. Writer observed resident grab the remote control away R2 would not let go off [of] the asked both resident[s] to stop remote, R2 left the remote. As esident [R1] lost his balance buttock. Staff immediately, esidents. R2 was directed to the other TV to watch his ded for rest of shift." Der 341538 dated 4/21/21, atching TV in the dayroom over to R2 and began to argue mote control for the TV. R1 re the controller from R2's on the head. Nursing ervened and "caught" R1 "with ould not fall". 4/26/21, at 11:09 a.m. R1 R2] pushed each other. I ped over someone's foot and 4/26/21, at 12:20 p.m. NA-A at happened on 4/21/21, "right	dated 4/16/21, indicated R2 ing a verbal altercation with 1]. Writer observed resident grab the remote control away R2 would not let go off [of] the asked both resident[s] to stop remote, R2 left the remote. As esident [R1] lost his balance buttock. Staff immediately, esidents. R2 was directed to the other TV to watch his ded for rest of shift." Der 341538 dated 4/21/21, ratching TV in the dayroom over to R2 and began to argue mote control for the TV. R1 re the controller from R2's on the head. Nursing ervened and "caught" R1 "with ould not fall". 4/26/21, at 11:09 a.m. R1 R2] pushed each other. I ped over someone's foot and 4/26/21, at 12:20 p.m. NA-A at happened on 4/21/21, "right R1 stood up and started walked up to them [R1 and s going on here?' They [R1 ing at each other. R2 then hit as holding R1 because he has	 ge 2 ge 2 fe 689 the problem does not recur all resident failure. the problem does not recur all resident for the DON and/or des audit all incidents weekly for 4 withen randomly ongoing. Completing a verbal altercember were states is balance buttock. Staff immediately, esidents. R2 was directed to the the other TV to watch his ted for rest of shift." the controller from R2's on the head. Nursing ervened and "caught" R1 "with ould not fall". 4/26/21, at 11:09 a.m. R1 R2] pushed each other. I ped over someone's foot and 4/26/21, at 12:20 p.m. NA-A ti happened on 4/21/21, "right R1 stood up and started walked up to them [R1 and is going on here?' They [R1 ing at each other. R2 then hit as holding R1 because he has 	 ge 2 ge 2 ge 2 F 689 the problem does not recur all nursing staff will be reeducated on the facility accident/incident policy including reporting and documentation by the DON and/or designee will audit all incidents weekly for 4 weeks and then randomly ongoing. Completed by 5/24/2021. 3. As part of Sterling Park Healthcare Center ongoing commitment to quality assurance, the DON and/or ED will report identified concerns through the community's QA Process. acting TV in the dayroom over to R2 and began to argue mote control for the TV. R1 re the controller from R2's on the head. Nursing ervened and "caught" R1 "with ould not fall". 4/26/21, at 11:09 a.m. R1 R2] pushed each other. I ped over someone's foot and 4/26/21, at 12:20 p.m. NA-A at happened on 4/21/21, "right R1 stood up and started walked up to them [R1 and s going on here?" They [R1 ing at each other. R2 then hit as holding R1 because he has 	

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES					FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			0	(X3) DATI	E SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CO	DE	-	
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STERLIN	IG PARK HEALTH CA	RECENTER			WAITE PARK, MN 56387			
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	indicated on 4/16/2 medications "out of trying to grab the re- of the remote and h and got himself off noted. I took R2 to physical contact ma contact was with the On 4/26/21, at 2:15 (DON) indicated sh altercation that occu- incident on 4/16/21 aware of a verbal a aware of R1 falling On 4/26/21, at 2:42 4/16/21, "R1 did fall up, so I checked hin no injuries." RN-A th over and took care the other side." Fur- there was a misund supposed to fill it [fa done. I am not sure a fall and she [RN-B report. It turns out the do one now, so I do knew about it [fall] of "she [RN-B] what ha the fall happen her boys [R1 and R2]. F happened I didn't te assumed [RN-B] kn	p.m. director of nursing e was made aware of the urred on 4/21/21. For the , DON indicated she was ltercation but she was not in result of the altercation. p.m. RN-A indicated on I and he basically got himself m to make sure he was ok and hen indicated RN-B "came of [R1] and I settled [R2] on ther, RN-A indicated "I think lerstanding RN-B was all report] out, but it was not e if she [RN-B] knew there was 3] was supposed to do the here was not one, so I have to o not know whether she [RN-B] or not." RN-A then indicated ght there standing. I didn't tell ppened. She [RN-B] didn't see [RN-B] back was facing the RN-B knew the altercation ell [RN-B] about the fall. I just new about it so that is where						
		tion is I think." In addition, the facility's fall protocol, RN-A						

If continuation sheet Page 4 of 6

PRINTED: 05/20/2021

		AND HUMAN SERVICES				FORM	05/20/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
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STERLIN	IG PARK HEALTH CA	RE CENTER			142 NORTH FIRST STREET WAITE PARK, MN 56387		
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F 689	indicated "after a fa report and we [staff] we [staff] have done the DON." Further, were not implement [R1] was RN-B's pa was the fact that the the remote from ea R2 away was the in On 4/26/21, at 2:52 see him [R1] fall. R to the chair and I we Further, RN-B state RN-A did not say ar [RN-A] assumed I k "no interventions or because I didn't kno conversation with R and get staff first. W [the altercation] on altercation with a re the altercation occu On 4/26/21, at 3:09 was aware of the in week" on 4/21/21, k incident were R1 ac altercation where a because R1 was pu lost balance." In ad facility fall protocol falls the nurse does full assessment of I administrator is call interventions are im involved at that time the DON and myse	all we [staff] do an incident fall [] say what happened and what e about it. Also need to inform RN-A confirmed interventions ted following R1's fall and "that atient. The contributing factor ey [R1 and R2] were grabbing ich other. The fact that I took itervention." P. p.m. RN-B stated "I did not 1 was already up and walking ent and talked with R1." ed "I did not know he fell and nything. I don't know if she knew." In addition, RN-B stated r incident report was made ow he fell. I did have a verbal R1 to not take it upon himself Ve [RN-A and RN-B] passed it through report that R1 had an esident" RN-B then indicated urred on 4/16/21. P. p.m. RN-C indicated RN-C ncident that occurred "last out was not aware "of an ctually fell. I know there was an staff actually caught R1 ulling it [the remote] back and dition, when asked what the was, RN-C stated "if a resident is a complete assessment and limbs. Doctor, family, DON and	F	689			

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DAT	<u>0938-0391</u> E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		IPLETED
		245375	B. WING				C 26/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
STERLIN	IG PARK HEALTH CA	RE CENTER			142 NORTH FIRST STREET NAITE PARK, MN 56387		
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PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU						COMPLETION DATE
F 689	Continued From pa	ae 5	Fe	00			
	stated "I don't recall a fall being discussed. I remember." On 4/26/21, at 3:17 p.m. when asked about		FU	009			
	On 4/26/21, at 3:17 facility fall protocol, on the floor the nurs use the hoyer to ge does the resident ju talked with the nurs implementing it into a fall without injury text message. Staff they [staff] add deta witness actions take interventions to pre again. It sounds like however she [RN-A Facility document ti Guidelines reviewed was "to ensure ade place to decrease, and ensure residen dignity and highest Further, facility doc procedure included resident for injury, o pressures and vital notifications. Facility to begin the root ca reviews the informa root cause and initia information. In addi	p.m. when asked about the DON stated "if the resident is se will assess the resident and t the resident up. Very rarely imp up. I went down and e [RN-A] and she is o risk management now. If it is they [staff] update me through follow the fall process where ails related to injuries, effect, en, vitals and try to implement vent it [fall] from happening e this is a miscommunication,] is putting it in now." tled Fall Risk and Prevention d 1/21, indicated the purpose quate interventions are in limit and prevent resident falls t safety while maintaining their practical level of abilities." ument indicated post fall immediately assess and treat complete orthostatic blood signs, and make appropriate y document then directs staff use analysis and the nurse ation collected to determine the ates a plan based on the tion, document indicated the ated and revised with changes					

Facility ID: 00643

If continuation sheet Page 6 of 6

PRINTED: 05/20/2021



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 7, 2021

Administrator Sterling Park Health Care Center 142 North First Street Waite Park, MN 56387

Re: State Nursing Home Licensing Orders Event ID: 580K11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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

Page 2

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:

Kathleen Lucas, Unit Supervisor St. Cloud B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us Office: (320) 223-7343 Mobile: (320) 290-1155

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

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

Please feel free to call me with any questions.

Miching

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00643	B. WING			C 2 6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
	IG PARK HEALTH CA	142 NOR	TH FIRST ST			
STERLIN		WAITE PA	RK, MN 563	387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	your facility by surve Department of Hea found NOT in comp Licensure. Please in of correction you have identify the date wh	S: blaint survey was conducted at eyors from the Minnesota th (MDH). Your facility was bliance with the MN State ndicate in your electronic plan ave reviewed these orders and en they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 05/17/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 8

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00643	B. WING			C 04/26/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
	TROVIDER OR SOFFEIER		TH FIRST STF				
STERLIN	IG PARK HEALTH CA	RECENTER	ARK, MN 563				
(X4) ID			ID	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE	
				DEFICIENCY	()		
2 000	Continued From pa	ige 1	2 000				
		-					
	The following comp	plaint was found to be					
	SUBSTANTIATED:	H5375047C (MN72133) with					
	a licensing order is	sued at (1665).					
	Minnesota Departm	nent of Health is documenting					
		Correction Orders using					
		ag numbers have been					
		ota state statutes/rules for					
		e assigned tag number					
		eft column entitled "ID Prefix					
		atute/rule out of compliance is ary Statement of Deficiencies"					
		es the "To Comply" portion of					
		r. This column also includes					
		are in violation of the state					
		tement, "This Rule is not met					
		ollowing the surveyor's findings					
	Time Period for Co	Method of Correction and					
		participate in the electronic					
		insure orders consistent with					
	the Minnesota Depa						
		tin 14-01, available at					
	•	state.mn.us/facilities/regulatio					
		_1.html The State licensing					
		ed on the attached Minnesota Ith orders being submitted to					
	•	Although no plan of correction					
		ate Statutes/Rules, please					
		RRECTED" in the box					
		ou must then indicate in the					
		ensure process, under the					
		n date, the date your orders will					
		o electronically submitting to artment of Health. The facility					
		and therefore a signature is					
		bottom of the first page of					
	state form.	······································					

	ita Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3) D	ATE SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING		OMPLETED
		00643	B. WING		C)4/26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
		142 NORT		IREET	
SIERLIN	IG PARK HEALTH CA	RE CENTER WAITE PA	RK, MN 56	387	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
21665	Continued From pa	ge 2	21665		
21665	MN Rule 4658.1400) Physical Environment	21665		5/24/21
	A nursing home m	ust provide a safe, clean,			
		able, and homelike physical			
	environment, allowi	ng the resident to use			
	personal belonging	s to the extent possible.			
	This MN Requirem	ent is not met as evidenced			
	by:				
		and document review, the		F (F689)	
		prehensively assess and		PLAN OF CORRECTION	
		ns to provide adequate safety		Sterling Park Healthcare Center denies	
		esident verbal altercation for 2		violated any federal or state regulations	
		wed (R1, R2), which resulted ion, a subsequent resident to		Accordingly, this plan of correction does not constitute an admission or agreeme	
		tercation which had the		by the provider to the accuracy of the fa	
	potential to result in			alleged or conclusions set forth in the	
				statement of deficiencies. The plan of	
	Findings include:			corrections is prepared and/or executed	1
	D4le au enterlu resimin	and data ant (MDC) datad		solely because it is required by the	
		nal data set (MDS) dated R1 had diagnoses that		provisions of federal and state law. Completion dates are provided for	
		and Parkinson's disease.		procedural processing purposes and	
		DS, indicated R1 did not		correlation with the most recently	
		nd has had one fall with injury.		completed or accomplished corrective	
				action and do not correspond	
		dated 4/16/21, indicated R1		chronologically to the date the facility	
		verbal altercation with another r. Confusion over who was in		maintains it is in compliance with the	
		sion of TV [television] remote.		requirements of participation, or that corrective action was necessary.	
		to inform staff, cannot walk		concourse double was neededdary.	
		ident and attempt to remove		1. In continuing compliance with	
		t moved to atrium to watch		F 689 The facility will ensure all residen	ts
		of R1's progress notes, dated		have an environment free of accident	
		had a physical altercation		hazards as is possible and receive	
		and staff immediately		adequate supervision and assistance to)
	separated R1 and F	≺∠.		prevent accidents. Sterling Park Healthcare Center corrected the	

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If continuation sheet 3 of 8

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00643			(X3) DATE S COMPL	ETED
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE TREET		
	IG FARR HEALIN CA	WAITE PA	ARK, MN 56	387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLE DATE
21665	Continued From pa	ge 3	21665			
	R1's Progress notes through 4/26/21, did altercation with R2 of R1's care plan print at risk for falls relate with shuffled gait, d awareness, and his care plan, indicated in bathroom. Howeve evidence to address and interventions w reoccurrence and in R2's progress note "was observed havi another resident [R [R1] attempting to g from R2. However, remote. After staff a grabbing on to the r a result, the other re and fall [fell] on his separated the two r the atrium and utiliz show where he sett Facility report numb indicated R2 was w and R1 ambulated of over wanting the re attempted to remov hand and R2 hit R1 assistant (NA)-A int her arms" so R1 "w During interview on stated "we [R1 and	s reviewed from 4/16/21 d not address R1's fall due to on 4/16/21. ed 4/26/21, indicated R1 was ed to end stage Parkinson's ementia with poor safety tory of falls. Further review of R1's last fall was on 2/20/21 ver, R1's care place lacked s fall that occurred on 4/16/21, ere not added to prevent njury. dated 4/16/21, indicated R2 ng a verbal altercation with 1]. Writer observed resident yrab the remote control away R2 would not let go off [of] the asked both resident[s] to stop emote, R2 left the remote. As esident [R1] lost his balance buttock. Staff immediately, esidents. R2 was directed to the other TV to watch his led for rest of shift." over 341538 dated 4/21/21, atching TV in the dayroom over to R2 and began to argue mote control for the TV. R1 the the controller from R2's on the head. Nursing ervened and "caught" R1 "with		 deficiency by: ensuring R1 and care planned interventions to priverbal resident to resident alterd and, R1 has care planned fall printerventions. To ensure all like have appropriate interventions to has audited all incidents in the problem does not recur all in staff will be reeducated on the far accident/incident policy including and documentation by the DON designee. The DON and/or desiaudit all incidents weekly for 4 w then randomly ongoing. Complete/24/2021. 3. As part of Sterling Park Healt Center ongoing commitment to assurance, the DON and/or ED identified concerns through the community's QA Process. 	event cations revention resident he facility bast 30 ventions /2021. to ensure ursing acility g reporting and/or gnee will veeks and eted by hcare quality will report	

If continuation sheet 4 of 8

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00643	B. WING			C 26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA		TH FIRST STR ARK, MN 5638			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21665	Continued From pa	ige 4	21665			
	indicated an incider after supper. I saw walking up to R2. I R2] and said 'what' and R2] started yel R1 on the neck. I w	4/26/21, at 12:20 p.m. NA-A nt happened on 4/21/21, "right R1 stood up and started walked up to them [R1 and s going on here?' They [R1 ling at each other. R2 then hit vas holding R1 because he has then indicated the two arated.				
	On 4/26/21, at 1:46 p.m. registered nurse (RN)-A indicated on 4/16/21, while RN-A was passing medications "out of the corner of my eye I saw R1 trying to grab the remote off R2. I told R2 to let go of the remote and he did. In the process R1 fell and got himself off [the floor] and no injuries were noted. I took R2 to the atrium. There was no physical contact made between them the only contact was with the remote."					
	(DON) indicated sh altercation that occ incident on 4/16/21 aware of a verbal a	p.m. director of nursing e was made aware of the urred on 4/21/21. For the , DON indicated she was ltercation but she was not in result of the altercation.				
	4/16/21, "R1 did fal up, so I checked hi no injuries." RN-A t over and took care the other side." Fur there was a misund	p.m. RN-A indicated on I and he basically got himself m to make sure he was ok and hen indicated RN-B "came of [R1] and I settled [R2] on ther, RN-A indicated "I think derstanding RN-B was all report] out, but it was not	1			
	done. I am not sure a fall and she [RN-I report. It turns out t	 a) if she [RN-B] knew there was B] was supposed to do the b) here was not one, so I have to c) not know whether she [RN-B] 				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00643	B. WING		04/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
STERLIN	IG PARK HEALTH CA	RF CENTER	TH FIRST STR ARK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
				DEFICIENC	Y)	
21665	"she [RN-B] was rig her [RN-B] what ha the fall happen her boys [R1 and R2]. F happened I didn't te assumed [RN-B] kn the miscommunicat when asked about t indicated "after a fa report and we [staff we [staff] have done the DON." Further, were not implement [R1] was RN-B's pa was the fact that the	or not." RN-A then indicated the there standing. I didn't tell ppened. She [RN-B] didn't see [RN-B] back was facing the RN-B knew the altercation ell [RN-B] about the fall. I just new about it so that is where tion is I think." In addition, the facility's fall protocol, RN-A II we [staff] do an incident fall] say what happened and what a about it. Also need to inform RN-A confirmed interventions ted following R1's fall and "that titient. The contributing factor ey [R1 and R2] were grabbing ch other. The fact that I took	t			
	see him [R1] fall. R to the chair and I we Further, RN-B state RN-A did not say ar [RN-A] assumed I k "no interventions or because I didn't kno conversation with R and get staff first. W [the altercation] on a altercation with a re the altercation occu On 4/26/21, at 3:09 was aware of the in week" on 4/21/21, k incident were R1 ac altercation where a	p.m. RN-B stated "I did not 1 was already up and walking ent and talked with R1." ed "I did not know he fell and nything. I don't know if she mew." In addition, RN-B stated incident report was made by he fell. I did have a verbal to not take it upon himself Ve [RN-A and RN-B] passed it through report that R1 had an esident" RN-B then indicated irred on 4/16/21. p.m. RN-C indicated RN-C cident that occurred "last but was not aware "of an estaff actually caught R1 ulling it [the remote] back and				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 04/26/2021		
		00643					
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
TERLIN	G PARK HEALTH CA		TH FIRST STR ARK, MN 5638				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21665	Continued From page 6		21665				
	facility fall protocol was, RN-C stated "if a resident		t				
	falls the nurse does a complete assessment and						
		limbs. Doctor, family, DON and	l l				
	administrator is called. The immediate						
	interventions are implemented by the nurses						
	involved at that time and then it is reviewed with						
	the DON and myself in interdisciplinary team						
	rounds and add more if needed." Further, RN-C						
	stated "I don't recall a fall being discussed. I don't remember."						
	Temember.						
	On 4/26/21, at 3:17 p.m. when asked about the						
	facility fall protocol, DON stated "if the resident is						
	on the floor the nurse will assess the resident and						
	use the hoyer to get the resident up. Very rarely						
	does the resident jump up. I went down and						
	talked with the nurse [RN-A] and she is						
	implementing it into risk management now. If it is a fall without injury they [staff] update me through						
	text message. Staff follow the fall process where						
	they [staff] add details related to injuries, effect,						
	witness actions taken, vitals and try to implement						
		vent it [fall] from happening					
		e this is a miscommunication,					
	however she [RN-A	A] is putting it in now."					
	Eacility document ti	itled Fall Risk and Prevention					
		d 1/21, indicated the purpose					
		equate interventions are in					
		limit and prevent resident falls					
	and ensure residen	it safety while maintaining their	•				
		practical level of abilities."					
		ument indicated post fall					
		immediately assess and treat					
		complete orthostatic blood					
		signs, and make appropriate					
		y document then directs staff use analysis and the nurse					
		ation collected to determine the					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00643		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		B. WING		04/	04/26/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
TERLIN	IG PARK HEALTH CA	ARE CENTER	TH FIRST STR ARK, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From page 7		21665			
	information. In addition, document indicated the plan of care is updated and revised with changes as indicated.					
	director of nursing develop, review, ar procedures for fall provide training to could develop mon	THOD OF CORRECTION: The (DON) or designee could nd/or revise policies and protocol. The DON could all staff. The DON or designee intoring systems to ensure se and report those results to noce committee.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				