DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 15, 2025

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

RE: CCN: 245375
Cycle Start Date: February 26, 2025

Dear Administrator:

On March 26, 2025, we notified you a remedy was imposed. On February 26, 2025 the Minnesota Department of Health 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 April 7, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 26, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 26, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 26th, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 7, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

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April 15, 2025

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

Re: Reinspection Results
Event ID: Y8ML12

Dear Administrator:

On April 9, 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 March 26, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 26, 2025

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

RE: CCN: 245375
Cycle Start Date: February 26, 2025

Dear Administrator:

On March 12, 2025, we informed you that we may impose enforcement remedies.

On March 20, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 26, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 26, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 26, 2025.

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.

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

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 May 26, 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 May 26, 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 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 an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 - Health Regulation Division 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 August 26, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	C 03/20/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/19/25 through 3/20/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed during the survey: H53751282C (MN00111474). As a result of the investigation a deficiency was cited at F580. 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 that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		4/7/25

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

Electronically Signed | 04/01/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	Sterling Park Healthcare Center denies it	

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F 580	Continued From page 2 facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a right lower leg abscess worsened and required hospitalization. Findings include: R1's admission Minimum Data Set dated 2/12/25, identified intact cognition without behaviors. He had a functional impairment of the upper extremities located on one side, used a walker, and a motorized wheelchair for mobility. He required substantial/maximal assistance for personal/toilet hygiene, dressing, bathing, partial/moderate assistance lying to sit, sit to stand, and all transfers. Ambulation was not attempted due to medical conditions or safety concerns. Medical diagnoses included peripheral vascular disease (PVD) (arteries became narrowed or blocked, reduced blood flow to extremities, most often feet and legs), cerebrovascular accident (CVA) (stroke), hemiplegia/hemiparesis (significant weakness or paralysis in one half of the body), and at risk for pressure ulcers. R1's care plan dated 3/6/25, identified he had an activities of daily living (ADL) self-care performance deficit related to CVA and weakness from acute illness. Staff were directed to report any changes in skin such as redness and bruising to nurse and observe/document/report to medical practitioner as needed (PRN) any changes in medical status, reasons for self-care deficit, expected course, and decline in function. He had potential for pressure injury development related to Braden scale (a tool used to assess the risk for developing pressure ulcers) score 13-14 (moderate risk) and surgical incision to right lower	F 580	violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F580, Notify of Changes, Sterling Park Healthcare Center corrected the deficiency for all residents by completing re-education with all licensed nursing staff of change in condition identification and process guideline by 4/7/2025. 2. To ensure continued compliance DNS/or designee will audit resident documentation for change in condition and appropriate follow up beginning 4/7/2025 -4x per week for 4 weeks, 3x/week x 4 weeks, then 2 x/week x 4 weeks, then PRN to ensure compliance with facility process. 3. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED and/or designee will	

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F 580	Continued From page 3 extremity (RLE). Staff were directed to administer treatments as ordered and observe for effectiveness, observe dressing to ensure it was intact, properly placed, report loose dressing to the nurse, stress the importance of frequent repositioning, and notification to family and medical provider of any new area of skin breakdown or worsening in status of current area. R1's progress notes from 3/1/25 through 3/4/25, identified: -3/1/25 at 5:54 p.m. Skilled Charting -Skin/wound integrity alterations: yes and no, moisture associated skin damage on buttocks. Treatments: application of ointments/creams/medications. No edema or pain. -3/2/25 at 11:31 a.m. Complained of right lower extremity pain 7 out of 10, refused Tylenol. -3/2/25 at 12:36 p.m. Received acetaminophen 500 milligrams (mg) orally for generalized pain in right leg. -3/2/25 at 1:22 p.m. Acetaminophen was effective. -3/2/25 at 1:50 p.m. Skilled Charting -Skin/wound integrity alterations: none. No edema or pain. -3/3/25 at 8:08 a.m. physical therapy (PT) service notes: R1 began therapy session via exercises on lower extremities. He was asked to complete the right lower extremity exercises, he stated he was unable to, due to pain 7 out of 10. PT assistant lifted his pant leg and saw a softball sized pocket of swelling on the mid-calf. PT brought him to director of nursing (DON) for assessment and requested no further lower extremity exercise or mobility until further assessed. -3/3/25 at 10:42 a.m. Right lower leg: pain 7/10, very tender and hot to touch, taut, 22 centimeters (cm) x 11 cm x 4 cm of a bulge coming out of the	F 580	report identified concerns through the community's QA Process. 4. The DNS is Responsible for this area of compliance.	

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F 580	Continued From page 4 lower right side of leg, unable to move his leg or walk, winces and groans/moans when he tried to move his leg. Pain radiated up leg to top of knee. Provider notified phone call (PC), spoke to nurse, she was going to notify nurse practitioner (NP) and return PC back with direction/orders. -3/3/25 at 11:13 a.m. New orders per NP: ultrasound (US) RLE diagnosis (DX) swelling and rule out (r/o) deep vein thrombosis (DVT) (blood clot) and doxycycline 100 mg by mouth (po) two times a day (BID) times seven days. DON was aware. -3/3/25 at 12:24 p.m. Phone call to schedule US per order, they will call with estimated time of arrival to complete US. -3/3/25 at 5:48 p.m. Orders- administration note: Initial that pain was observed every shift. Document any verbal and/or non-verbal indicators of pain and interventions, including non pharmalogical interventions in pain progress note, two times a day. Severe pain noted, right lower edema, provider notified, US on RLE this evening at 5:00 p.m. -3/4/25 at 9:11 a.m. Electronic medication administration record (EMAR): Resident received Tylenol 500 mg orally for pain rated 7 out of 10. -3/4/25 at 12:32 p.m. Per NP, send R1 to emergency room (ER) for RLE. He agreed, consent for bed hold received. He signed form and emergency medical system (EMS) transported to local hospital at 12:50 p.m. -3/4/25 at 12:49 p.m. R1 was sent to ER due to suspected infection of the lower extremity. -3/4/25 at 3:39 p.m. PT service notes: He reported high pain in the right lower extremity with softball sized swelling on the mid-calf. Nursing updated and NP here to see pt today. R1's ER/hospital after visit summary dated	F 580		

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F 580	Continued From page 5 3/4/25, Reason for visit: cellulitis. Diagnoses: Hematoma and cellulitis of the right lower extremity. Instructions: The large lump on the outside of the right leg is a "hematoma". We have concerned [sic] that hematoma which is a collection of old blood likely previous trauma is may [sic] infected. Please take the antibiotics as prescribed and return if you are having increasing right leg pain, swelling, fevers. Call your doctor now or seek immediate medical care if: you have signs your infection is getting worse such as: increased pain, new or worse swelling, warmth, or redness, red streaks leading from the area, pus draining from the area, a fever, or you get a rash. R1's progress notes from 3/5/25 through 3/11/25, identified: -3/5/25 at 7:47 a.m. Per ER visit with a diagnosis of hematoma (a collection of blood outside of blood vessels that can form in any part of the body from ruptured blood vessels that cause symptoms such as swelling, bruising, and pain)/cellulitis (a common bacterial infection of the skin and underlying tissue and causes redness, swelling, pain and warmth in the affected area) of the right lower extremity. Labs basic metabolic panel (BMP) (measures several key substances in the body including electrolytes, blood sugar, kidney function, and liver function), c-reactive protein (a protein produced by the liver in response to inflammation), an incision and drain was performed. Dressing clean, dry, and intact (CDI). -3/5/25 at 4:24 p.m. Non-pressure Ulcer/injury assessment: initial assessment completed on new area a surgical wound, measured length 0.7 cm, width 0.2 cm, and depth 0. Peri wound: bloody drainage noted surrounding skin warm	F 580		

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F 580	Continued From page 6 and pink hued, no odor present. Doctor was notified of new skin condition on 3/4/25. New wound, seen in ER on 3/4/25 and area was lanced to allow for drainage. -3/5/25 at 6:41 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatment: non-sterile dressing changes. No edema or pain. -3/6/25 at 8:09 a.m. PT service notes: he continued to have pain in RLE which limited his range of motion (ROM), standing, and ambulation. Nursing was aware of RLE pain. -3/6/25 at 10:04 a.m. Acetaminophen 500 mg administered for complaints of mild pain in right leg and rated pain at 6 out of 10. -3/6/25 at 11:55 a.m. Administration of acetaminophen was effective pain at 3 out of 10. -3/6/25 at 3:05 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-sterile dressing changes. No edema or pain. -3/6/25 at 3:07 p.m. Body audit completed. Alternations in skin integrity identified: Right lower leg (front) hematoma and small incision was drained at local hospital. Fingernails and toenails clean and trimmed. Inspection of heels indicated firm. Edema in lower extremities noted. -3/7/25 at 11:59 a.m. he was hesitant to work on standing, declined attempts to walk, refused to bear full weight on RLE, and had increased soreness during weight shifting, and remained limited by the pain. Nursing was aware of his RLE pain and monitored the swelling. -3/7/25 at 12:00 a.m. Regulatory visit by medical doctor (MD): . . . musculoskeletal exam: right lower leg showed a firm mass about 3 cm in diameter with a central incision which was clean, dry and no drainage. Lesion was not fluctuant (did not feel soft or squishy like a fluid-filled area but	F 580		

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	245375	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 580	Continued From page 7 instead felt firm/solid), was not warm, red, or tender. . . -3/7/25 at 5:01 p.m. Skilled Charting -Skin/wound integrity alterations: pressure ulcer on buttocks. Treatments: cream. No edema or pain. -3/7/25 at 8:42 a.m. Acetaminophen 500 mg administered for pain 5 out of 10. -3/7/25 at 11:25 a.m. Follow up pain 6/10, administration of acetaminophen: ineffective. -3/7/25 at 5:21 p.m. Administration of acetaminophen 500 mg for pain 7 out of 10. -3/7/25 at 8:30 p.m. Follow up pain 0/0, was effective. -3/8/25 at 7:18 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer, location unidentified. Treatments: cream. Edema, yes, 2 plus (+) moderate pitting, indentation subsided rapidly. No pain. -3/8/25 at 7:21 a.m. He had a boil or cysts looking mass to the right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He complained of moderate to no pain in both right leg and left elbow. He had sat for house on wheelchair without elevating his legs. The resident was encouraged to ask for help in elevating his feet. -3/8/25 at 8:23 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/35 at 9:24 a.m. Follow up pain 7 out of 10, was ineffective. -3/8/25 at 12:21 p.m. Skilled Charting -Skin wound integrity alterations: no. Edema, yes, 1+ mild pitting, slight indention, no perceptible swelling of the leg. No pain. -3/8/25 at 4:43 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/25 at 7:36 p.m. Follow up pain 0 out of 10, was effective.	F 580		

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F 580	Continued From page 8 -3/9/25 at 5:41 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. -3/9/25 at 8:36 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/9/25 at 11:24 a.m. Follow up pain 5 out of 10, was effective. -3/9/25 at 12:25 p.m. Skilled Charting -Skin wound integrity alterations: yes, other, right leg swollen. Treatments, none. Edema, yes, 1+ mild pitting, slight indentation, no perceptible swelling of the leg. -3/9/25 at 4:36 p.m. Acetaminophen 500 mg administered for pain for pain 7 out of 10. -3/9/25 at 8:41 p.m. Follow up pain: unknown. -3/10/25 at 3:33 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/10/25 at 10:12 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/10/25 at 1:37 p.m. Follow up pain 0 out of 10, was effective. -3/10/25 at 5:26 p.m. Skilled Charting -Skin/wound integrity alterations: yes, pressure ulcers/buttocks, and hematoma to right calf. Treatments cream and non-surgical dressing changes. No edema or pain. -3/11/25 at 12:00 a.m. Provider update/visit: re-evaluation of his right lower leg. Appeared worse than visit one week ago when he was set to ER, incision and drainage (I & D) was attempted for abscess. Doxycycline and Cephalexin for seven days. Today right lower leg increased in size, warm, and redness. Denies fever or chills. Continues to appear a pocket of fluid collection left lateral aspect of leg down to ankle. Therapy reporting difficulty standing,	F 580		

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F 580	Continued From page 9 weight bearing which is new for him. He is agreeable to ER evaluation for worsening abscess related to (r/o) osteomyelitis (infection of the bone). Signed by NP on 3/11/25 at 12:18 p.m. -3/11/25 at 6:03 a.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-surgical dressing change. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/11/25 at 7:39 a.m. Acetaminophen 500 mg administered . . . resident complained of severe moderate pain on his right leg, rated his pain at 7 out of 10. -3/11/25 at 9:21 a.m. Follow up pain 4 out of 10, was effective. -3/11/25 at 11:38 a.m. Occupational therapy (OT) notes: he stood for two minutes times three then declined working on any functional reaching tasks due to RLE pain 5 out of 10. -3/11/25 at 2:58 p.m. NP looked at resident's wound and was warm to touch . . . he was sent to ER for evaluation. -3/11/25 at 5:12 p.m. Skilled Charting -Skin/wound integrity alterations, yes hematoma to right leg, warm to touch, increased swelling. Sent to ER for evaluation. Treatments: non-surgical dressing change. Edema present 2+ moderate, pitting, indentation subsides rapidly. No pain. -3/11/25 at 6:59 p.m. Resident's right lower leg assessed by NP today at on-site visit. His wound was warm to touch and had increased swelling. Pain to touch and with movement on 4 to 6/10. No drainage noted. NP recommended resident be sent to ER for evaluation. Resident went to ER via non-emergent transport around 12:00 p.m. -3/11/25 at 11:56 p.m. Nurse called local hospital for follow-up; resident was admitted with cellulitis.	F 580		

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F 580	Continued From page 10 Emergency department (ED) to hospital admission 3/11/25 through 3/14/25, identified discharge diagnoses: right distal lower extremity hematoma. Hospital course: presented to ER on 3/11/25 with right leg discomfort and swelling. He had been recently seen in ER on 3/4/25 with right leg pain and swelling and at that time had an elevated leukocytosis (white blood cells indicated infection). An incision and drainage (I&D) were performed for suspicion of abscess and infected hematoma of the right leg but appeared to be more of an old hematoma. There was some concern for cellulitis so was placed on a course of two antibiotics, Doxycycline and Keflex then discharged. He reported right leg pain and enlargement for one week. A magnetic resource imaging (MRI) of right calf was completed and showed heterogeneous (appeared uniformity in texture or composition) mass in the subcutaneous aspect of the lateral calf which appeared most consistent with hematoma. Ultimately was felt that it was a hematoma and there was no infection. Orthopedics recommended a heat and ice compression. Physical exam identified a 5 cm by 4 cm area of swelling and fluctuance (subject to change, variable, or capable of being moved or compressed) in the lateral aspect of his distal right lower extremity. No warm or redness noted. R1's progress notes from 3/14/25 through 3/15/25, identified: -3/14/25 at 3:23 p.m. Resident readmitted to facility after being hospitalized . . . diagnosis: hematoma of the right calf. -3/15/25 at 12:29 p.m. Skilled Charting -Skin wound integrity alterations: yes, hematoma to right leg, warm to touch, increased swelling	F 580		

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F 580	Continued From page 11 resolving. Treatments: non-surgical dressing changes. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. During an interview on 3/20/25 at 10:18 a.m. registered nurse (RN)-A stated R1 was admitted to the facility beginning of February 2025 with respiratory and cardiac issues. She saw him on 2/26/25 and 2/27/25 and was not aware of any skin concerns at that time. On 3/5/25 he returned from the hospital, staff would be expected to assess his right lower leg wound and dressing, complete daily dressing changes, assessments, and document. On 3/8/25 the staff nurse should have contacted the provider and updated them regarding a change in condition. He was already on an antibiotic but may had needed to go to ER and could have possibly avoided another visit. During an interview on 3/20/25 at 11:21 a.m. RN-B started she had seen R1 on 3/5/25 when he returned to facility from the hospital. She removed the dressing located on his right lower leg and noted bloody drainage without odor. She cleaned the wound with normal saline, completed the weekly non-pressure ulcer/injury assessment and applied a dressing. The floor nurses were responsible to monitor it and update her if there were changes. On 3/8/25 the staff nurse charted there was a change in condition and a provider should have been notified and updated to see what steps should have been taken next. R1 did not have a pressure ulcer but had been documented by staff nurses he did. The skilled assessments were completed and used to show a change in condition. A provider could have reached 24/7 and communicated with via email. During an interview on 3/20/25 at 11:57 p.m.	F 580		

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F 580	Continued From page 12 nurse practitioner (NP) stated R1 was sent to ER on 3/4/25 and diagnosed with cellulitis and started on antibiotics. MD saw him on 3/7/25. She saw him on 3/11/25, and his right lower leg was much redder, swollen, hot to the touch, and did not look any better than when she saw him on 3/4/25. There was fluid collection noted and she would empower the nursing staff to have updated and let the provider know. She had not been contacted from 3/5/25 to 3/11/25 with any concerns or change in condition. Staff would have been expected to complete a daily dressing change, skin assessments/monitoring of the wound, and error on the side of caution. He could have had osteomyelitis and possible sepsis, had taken antibiotics for two days with no improvement, should have been sent in right away instead. We maxed out for the facility management and may have not been able to meet his needs. During an interview on 3/20/25 at 1:14 p.m. medical doctor (MD) stated she had seen R1 at the facility during rounds on 3/7/25, and documented under the musculoskeletal section his right lower leg was clean, dry, no redness, swelling, approximately 3 cm in diameter, no tenderness, and no pus forming. He was placed on two antibiotics Doxycycline and Cephalexin, generally within 48 to 72 hours things should have started to improve. The nurse's documentation on 3/8/25 indicated a change in condition and she would have expected the nurse to have contacted a provider. R1 would have most likely been sent to ED sooner to determine if it were infected, and what to do next. During an interview on 3/20/25 at 2:09 p.m. RN-C stated she had documented on 3/8/25 at 12:21	F 580		

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F 580	Continued From page 13 p.m. a skilled assessment in R1's progress notes. She had too much in her head and forgot to click yes on skin alterations and entered no instead. R1 had refused to have his legs looked at on 3/8/25, and the night staff nurse had told her his right lower leg looked swollen on the outer side. Staff nurses would be expected to contact the provider if there was a concern and/or abnormal assessment regarding his right lower leg. During an interview on 3/20/25 at 2:33 p.m. licensed practical nurse (LPN)-A stated she had documented on 3/7/25 at 5:01 a.m. a skilled assessment on R1 which identified a pressure ulcer on his buttocks and had not included the right lower leg wound. On 3/8/25, a nursing assistant (NA) informed me his right lower leg did not look good. He had an area that was blistered, refused to off load, and encouraged to elevate his legs and was new to her. She stated on 3/8/25 at 7:31 a.m. she had written a progress note: R1 had a boil or cysts looking mass to right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He had no to moderate complaints of pain in both right lower leg and left elbow. She was not sure if that would have been considered a change in condition for R1, vital signs were normal and not much pain. She stated she had gotten off track at times, had forgotten things, and should have contacted a provider when he had a change in condition, and made aware of what was going on with him. The skin on his right lower leg was tight, looked as though something was going to pop open, puffy like it was swollen, without pain. She was not aware he had a surgical wound but saw there was a dressing over it. Nursing staff were expected to have completed a skilled nursing assessment every shift and included a skin	F 580		

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F 580	Continued From page 14 assessment. She had entered R1 had a pressure ulcer in the clinical assessment and unsure if he had one. During an interview on 3/20/25 at 4:07 p.m. DON stated on 3/4/25, R1 was sent to ER, had fluid drained off his right lower leg, started on two antibiotics, a diagnosis of cellulitis, and sent back to facility on 3/5/25. On 3/8/25, the staff nurse should have called the provider when she noticed a change in R1's condition. Would have been important to get further direction and orders regarding sending him into ER. Mostly likely would have sent him in earlier. During an interview on 3/21/25 at 8:42 a.m. rehab director (PT) stated she had reported to nursing R1 complained of soreness in the right lower leg that was ongoing. On 3/3/25, his right lower extremity had a softball sized pocket of swelling, and she had taken him to the DON to have it assessed. Between 3/3/25 and 3/11/25, he had refused to walk due to pain in his right lower leg. On 3/11/25, she had reported he had refused to walk again. During an interview on 3/21/25 at 3:52 p.m. RN-D stated staff nurses were expected to complete a skilled assessment on R1 two times in a 24-hour period. She collected the information for the skilled assessment while in the room with the resident through observation/assessment, and vital signs. She documented a skill nursing assessment on 3/2/25, no pain, no skin issues. She had not recalled any skin issues. He had pain in the right lower leg and documented in error no pain. She was unable to recall if she had physically assessed/observed him during the 3/2/25, assessment. He returned from the	F 580		

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F 580	Continued From page 15 hospital on 3/5/25, she completed a skilled assessment and documented no edema or pain. She stated R1 had a hematoma, a localized bump, pain in right leg when touched or moved. Pain was not documented in her assessment. She documented a skilled nursing assessment on 3/10/25, no pain, no edema, and pressure ulcer buttocks. She stated it was a documentation error, no pressure ulcer identified. She had completed a skill nursing assessment earlier in the day on 3/11/25, and he had increased swelling in his right lower leg later that day when dressing was changed, and NP had seen him. Staff were expected to notify a provider as soon as possible if there was a change in condition so that the resident would have received the treatment they needed. Facility policy Weekly Skin Assessment and Documentation Process dated 1/20/23, identified skin ulcers and non-ulcers will be assessed and documented weekly by the facility wound nurse. When the nurse on the floor observes a new skin/wound alteration they should utilize the fax forms to notify the physician/nurse practitioner or call and put the new order in point click care (PCC). If a skin/wound alteration exhibits any decline or non-healing when the floor nurse is completing treatment or wound nurse is assessing, that nurse will notify the physician, document the decline and notification on the assessment form, and in the nurse's notes. The hot chart and care plan will be updated as appropriate. The nurse will notify the DON for further support and guidance. Facility policy Notification of Change in Resident Health Status dated 2/8/23, identified resident's physician and resident's legal representative will	F 580		

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F 580	Continued From page 16 be notified of a change in resident status when the following occur: a. A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications b. A need to alter treatment significantly, for example a need to discontinue an existing treatment due to adverse consequences, or to begin a new form of treatment, c. A decision to transfer or discharge the resident from the nursing home.	F 580		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 26, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: Y8ML11

Dear Administrator:

The above facility was surveyed on March 19, 2025 through March 20, 2025 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 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00643	A. BUILDING: _____ B. WING _____	C 03/20/2025

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/19/25 through 3/20/25, a complaint 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 Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H53751282C (MN00111474). As a result of the investigation, licensing orders was issued at 0265. 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 14-01, available at 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	2 000		

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2 000	Continued From page 2 Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		4/7/25

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a right lower leg abscess worsened and required hospitalization. Findings include: R1's admission Minimum Data Set dated 2/12/25, identified intact cognition without behaviors. He had a functional impairment of the upper extremities located on one side, used a walker, and a motorized wheelchair for mobility. He required substantial/maximal assistance for personal/toilet hygiene, dressing, bathing, partial/moderate assistance lying to sit, sit to stand, and all transfers. Ambulation was not attempted due to medical conditions or safety concerns. Medical diagnoses included peripheral vascular disease (PVD) (arteries became narrowed or blocked, reduced blood flow to extremities, most often feet and legs), cerebrovascular accident (CVA) (stroke), hemiplegia/hemiparesis (significant weakness or paralysis in one half of the body), and at risk for pressure ulcers. R1's care plan dated 3/6/25, identified he had an activities of daily living (ADL) self-care	2 265	Sterling Park Healthcare Center denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F580, Notify of Changes, Sterling Park Healthcare Center corrected the deficiency for all residents by completing re-education with all licensed nursing staff of change in condition identification and process guideline by 4/7/2025. 2. To ensure continued compliance	

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2 265	Continued From page 4 performance deficit related to CVA and weakness from acute illness. Staff were directed to report any changes in skin such as redness and bruising to nurse and observe/document/report to medical practitioner as needed (PRN) any changes in medical status, reasons for self-care deficit, expected course, and decline in function. He had potential for pressure injury development related to Braden scale (a tool used to assess the risk for developing pressure ulcers) score 13-14 (moderate risk) and surgical incision to right lower extremity (RLE). Staff were directed to administer treatments as ordered and observe for effectiveness, observe dressing to ensure it was intact, properly placed, report loose dressing to the nurse, stress the importance of frequent repositioning, and notification to family and medical provider of any new area of skin breakdown or worsening in status of current area. R1's progress notes from 3/1/25 through 3/4/25, identified: -3/1/25 at 5:54 p.m. Skilled Charting -Skin/wound integrity alterations: yes and no, moisture associated skin damage on buttocks. Treatments: application of ointments/creams/medications. No edema or pain. -3/2/25 at 11:31 a.m. Complained of right lower extremity pain 7 out of 10, refused Tylenol. -3/2/25 at 12:36 p.m. Received acetaminophen 500 milligrams (mg) orally for generalized pain in right leg. -3/2/25 at 1:22 p.m. Acetaminophen was effective. -3/2/25 at 1:50 p.m. Skilled Charting -Skin/wound integrity alterations: none. No edema or pain. -3/3/25 at 8:08 a.m. physical therapy (PT) service notes: R1 began therapy session via exercises on lower extremities. He was asked to complete the right lower extremity exercises, he	2 265	DNS/or designee will audit resident documentation for change in condition and appropriate follow up beginning 4/7/2025 -4x per week for 4 weeks, 3x/week x 4 weeks, then 2 x/week x 4 weeks, then PRN to ensure compliance with facility process. 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. 4. The DNS is Responsible for this area of compliance.	

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2 265	Continued From page 5 stated he was unable to, due to pain 7 out of 10. PT assistant lifted his pant leg and saw a softball sized pocket of swelling on the mid-calf. PT brought him to director of nursing (DON) for assessment and requested no further lower extremity exercise or mobility until further assessed. -3/3/25 at 10:42 a.m. Right lower leg: pain 7/10, very tender and hot to touch, taut, 22 centimeters (cm) x 11 cm x 4 cm of a bulge coming out of the lower right side of leg, unable to move his leg or walk, winces and groans/moans when he tried to move his leg. Pain radiated up leg to top of knee. Provider notified phone call (PC), spoke to nurse, she was going to notify nurse practitioner (NP) and return PC back with direction/orders. -3/3/25 at 11:13 a.m. New orders per NP: ultrasound (US) RLE diagnosis (DX) swelling and rule out (r/o) deep vein thrombosis (DVT) (blood clot) and doxycycline 100 mg by mouth (po) two times a day (BID) times seven days. DON was aware. -3/3/25 at 12:24 p.m. Phone call to schedule US per order, they will call with estimated time of arrival to complete US. -3/3/25 at 5:48 p.m. Orders- administration note: Initial that pain was observed every shift. Document any verbal and/or non-verbal indicators of pain and interventions, including non pharmalogical interventions in pain progress note, two times a day. Severe pain noted, right lower edema, provider notified, US on RLE this evening at 5:00 p.m. -3/4/25 at 9:11 a.m. Electronic medication administration record (EMAR): Resident received Tylenol 500 mg orally for pain rated 7 out of 10. -3/4/25 at 12:32 p.m. Per NP, send R1 to emergency room (ER) for RLE. He agreed, consent for bed hold received. He signed form and emergency medical system (EMS)	2 265		

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2 265	Continued From page 6 transported to local hospital at 12:50 p.m. -3/4/25 at 12:49 p.m. R1 was sent to ER due to suspected infection of the lower extremity. -3/4/25 at 3:39 p.m. PT service notes: He reported high pain in the right lower extremity with softball sized swelling on the mid-calf. Nursing updated and NP here to see pt today. R1's ER/hospital after visit summary dated 3/4/25, Reason for visit: cellulitis. Diagnoses: Hematoma and cellulitis of the right lower extremity. Instructions: The large lump on the outside of the right leg is a "hematoma". We have concerned [sic] that hematoma which is a collection of old blood likely previous trauma is may [sic] infected. Please take the antibiotics as prescribed and return if you are having increasing right leg pain, swelling, fevers. Call your doctor now or seek immediate medical care if: you have signs your infection is getting worse such as: increased pain, new or worse swelling, warmth, or redness, red streaks leading from the area, pus draining from the area, a fever, or you get a rash. R1's progress notes from 3/5/25 through 3/11/25, identified: -3/5/25 at 7:47 a.m. Per ER visit with a diagnosis of hematoma (a collection of blood outside of blood vessels that can form in any part of the body from ruptured blood vessels that cause symptoms such as swelling, bruising, and pain)/cellulitis (a common bacterial infection of the skin and underlying tissue and causes redness, swelling, pain and warmth in the affected area) of the right lower extremity. Labs basic metabolic panel (BMP) (measures several key substances in the body including electrolytes, blood sugar, kidney function, and liver function), c-reactive protein (a protein produced by the liver	2 265		

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2 265	Continued From page 7 in response to inflammation), an incision and drain was performed. Dressing clean, dry, and intact (CDI). -3/5/25 at 4:24 p.m. Non-pressure Ulcer/injury assessment: initial assessment completed on new area a surgical wound, measured length 0.7 cm, width 0.2 cm, and depth 0. Peri wound: bloody drainage noted surrounding skin warm and pink hued, no odor present. Doctor was notified of new skin condition on 3/4/25. New wound, seen in ER on 3/4/25 and area was lanced to allow for drainage. -3/5/25 at 6:41 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatment: non-sterile dressing changes. No edema or pain. -3/6/25 at 8:09 a.m. PT service notes: he continued to have pain in RLE which limited his range of motion (ROM), standing, and ambulation. Nursing was aware of RLE pain. -3/6/25 at 10:04 a.m. Acetaminophen 500 mg administered for complaints of mild pain in right leg and rated pain at 6 out of 10. -3/6/25 at 11:55 a.m. Administration of acetaminophen was effective pain at 3 out of 10. -3/6/25 at 3:05 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-sterile dressing changes. No edema or pain. -3/6/25 at 3:07 p.m. Body audit completed. Alternations in skin integrity identified: Right lower leg (front) hematoma and small incision was drained at local hospital. Fingernails and toenails clean and trimmed. Inspection of heels indicated firm. Edema in lower extremities noted. -3/7/25 at 11:59 a.m. he was hesitant to work on standing, declined attempts to walk, refused to bear full weight on RLE, and had increased soreness during weight shifting, and remained limited by the pain. Nursing was aware of his RLE	2 265		

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2 265	Continued From page 8 pain and monitored the swelling. -3/7/25 at 12:00 a.m. Regulatory visit by medical doctor (MD): . . . musculoskeletal exam: right lower leg showed a firm mass about 3 cm in diameter with a central incision which was clean, dry and no drainage. Lesion was not fluctuant (did not feel soft or squishy like a fluid-filled area but instead felt firm/solid), was not warm, red, or tender. . . -3/7/25 at 5:01 p.m. Skilled Charting -Skin/wound integrity alterations: pressure ulcer on buttocks. Treatments: cream. No edema or pain. -3/7/25 at 8:42 a.m. Acetaminophen 500 mg administered for pain 5 out of 10. -3/7/25 at 11:25 a.m. Follow up pain 6/10, administration of acetaminophen: ineffective. -3/7/25 at 5:21 p.m. Administration of acetaminophen 500 mg for pain 7 out of 10. -3/7/25 at 8:30 p.m. Follow up pain 0/0, was effective. -3/8/25 at 7:18 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer, location unidentified. Treatments: cream. Edema, yes, 2 plus (+) moderate pitting, indentation subsided rapidly. No pain. -3/8/25 at 7:21 a.m. He had a boil or cysts looking mass to the right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He complained of moderate to no pain in both right leg and left elbow. He had sat for house on wheelchair without elevating his legs. The resident was encouraged to ask for help in elevating his feet. -3/8/25 at 8:23 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/35 at 9:24 a.m. Follow up pain 7 out of 10, was ineffective. -3/8/25 at 12:21 p.m. Skilled Charting -Skin wound integrity alterations: no. Edema, yes, 1+	2 265		

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2 265	Continued From page 9 mild pitting, slight indention, no perceptible swelling of the leg. No pain. -3/8/25 at 4:43 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/25 at 7:36 p.m. Follow up pain 0 out of 10, was effective. -3/9/25 at 5:41 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. -3/9/25 at 8:36 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/9/25 at 11:24 a.m. Follow up pain 5 out of 10, was effective. -3/9/25 at 12:25 p.m. Skilled Charting -Skin wound integrity alterations: yes, other, right leg swollen. Treatments, none. Edema, yes, 1+ mild pitting, slight indentation, no perceptible swelling of the leg. -3/9/25 at 4:36 p.m. Acetaminophen 500 mg administered for pain for pain 7 out of 10. -3/9/25 at 8:41 p.m. Follow up pain: unknown. -3/10/25 at 3:33 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/10/25 at 10:12 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/10/25 at 1:37 p.m. Follow up pain 0 out of 10, was effective. -3/10/25 at 5:26 p.m. Skilled Charting -Skin/wound integrity alterations: yes, pressure ulcers/buttocks, and hematoma to right calf. Treatments cream and non-surgical dressing changes. No edema or pain. -3/11/25 at 12:00 a.m. Provider update/visit: re-evaluation of his right lower leg. Appeared worse than visit one week ago when he was set to ER, incision and drainage (I & D) was attempted for abscess. Doxycycline and	2 265		

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2 265	Continued From page 10 Cephalexin for seven days. Today right lower leg increased in size, warm, and redness. Denies fever or chills. Continues to appear a pocket of fluid collection left lateral aspect of leg down to ankle. Therapy reporting difficulty standing, weight bearing which is new for him. He is agreeable to ER evaluation for worsening abscess related to (r/o) osteomyelitis (infection of the bone). Signed by NP on 3/11/25 at 12:18 p.m. -3/11/25 at 6:03 a.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-surgical dressing change. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/11/25 at 7:39 a.m. Acetaminophen 500 mg administered . . . resident complained of severe moderate pain on his right leg, rated his pain at 7 out of 10. -3/11/25 at 9:21 a.m. Follow up pain 4 out of 10, was effective. -3/11/25 at 11:38 a.m. Occupational therapy (OT) notes: he stood for two minutes times three then declined working on any functional reaching tasks due to RLE pain 5 out of 10. -3/11/25 at 2:58 p.m. NP looked at resident's wound and was warm to touch . . . he was sent to ER for evaluation. -3/11/25 at 5:12 p.m. Skilled Charting -Skin/wound integrity alterations, yes hematoma to right leg, warm to touch, increased swelling. Sent to ER for evaluation. Treatments: non-surgical dressing change. Edema present 2+ moderate, pitting, indentation subsides rapidly. No pain. -3/11/25 at 6:59 p.m. Resident's right lower leg assessed by NP today at on-site visit. His wound was warm to touch and had increased swelling. Pain to touch and with movement on 4 to 6/10. No drainage noted. NP recommended resident be	2 265		

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2 265	Continued From page 11 sent to ER for evaluation. Resident went to ER via non-emergent transport around 12:00 p.m. -3/11/25 at 11:56 p.m. Nurse called local hospital for follow-up; resident was admitted with cellulitis. Emergency department (ED) to hospital admission 3/11/25 through 3/14/25, identified discharge diagnoses: right distal lower extremity hematoma. Hospital course: presented to ER on 3/11/25 with right leg discomfort and swelling. He had been recently seen in ER on 3/4/25 with right leg pain and swelling and at that time had an elevated leukocytosis (white blood cells indicated infection). An incision and drainage (I&D) were performed for suspicion of abscess and infected hematoma of the right leg but appeared to be more of an old hematoma. There was some concern for cellulitis so was placed on a course of two antibiotics, Doxycycline and Keflex then discharged. He reported right leg pain and enlargement for one week. A magnetic resource imaging (MRI) of right calf was completed and showed heterogeneous (appeared uniformity in texture or composition) mass in the subcutaneous aspect of the lateral calf which appeared most consistent with hematoma. Ultimately was felt that it was a hematoma and there was no infection. Orthopedics recommended a heat and ice compression. Physical exam identified a 5 cm by 4 cm area of swelling and fluctuance (subject to change, variable, or capable of being moved or compressed) in the lateral aspect of his distal right lower extremity. No warm or redness noted. R1's progress notes from 3/14/25 through 3/15/25, identified: -3/14/25 at 3:23 p.m. Resident readmitted to facility after being hospitalized . . . diagnosis: hematoma of the right calf.	2 265		

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2 265	Continued From page 12 -3/15/25 at 12:29 p.m. Skilled Charting -Skin wound integrity alterations: yes, hematoma to right leg, warm to touch, increased swelling resolving. Treatments: non-surgical dressing changes. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. During an interview on 3/20/25 at 10:18 a.m. registered nurse (RN)-A stated R1 was admitted to the facility beginning of February 2025 with respiratory and cardiac issues. She saw him on 2/26/25 and 2/27/25 and was not aware of any skin concerns at that time. On 3/5/25 he returned from the hospital, staff would be expected to assess his right lower leg wound and dressing, complete daily dressing changes, assessments, and document. On 3/8/25 the staff nurse should have contacted the provider and updated them regarding a change in condition. He was already on an antibiotic but may had needed to go to ER and could have possibly avoided another visit. During an interview on 3/20/25 at 11:21 a.m. RN-B started she had seen R1 on 3/5/25 when he returned to facility from the hospital. She removed the dressing located on his right lower leg and noted bloody drainage without odor. She cleaned the wound with normal saline, completed the weekly non-pressure ulcer/injury assessment and applied a dressing. The floor nurses were responsible to monitor it and update her if there were changes. On 3/8/25 the staff nurse charted there was a change in condition and a provider should have been notified and updated to see what steps should have been taken next. R1 did not have a pressure ulcer but had been documented by staff nurses he did. The skilled assessments were completed and used to show a change in condition. A provider could have reached 24/7 and communicated with via email.	2 265		

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2 265	Continued From page 13 During an interview on 3/20/25 at 11:57 p.m. nurse practitioner (NP) stated R1 was sent to ER on 3/4/25 and diagnosed with cellulitis and started on antibiotics. MD saw him on 3/7/25. She saw him on 3/11/25, and his right lower leg was much redder, swollen, hot to the touch, and did not look any better than when she saw him on 3/4/25. There was fluid collection noted and she would empower the nursing staff to have updated and let the provider know. She had not been contacted from 3/5/25 to 3/11/25 with any concerns or change in condition. Staff would have been expected to complete a daily dressing change, skin assessments/monitoring of the wound, and error on the side of caution. He could have had osteomyelitis and possible sepsis, had taken antibiotics for two days with no improvement, should have been sent in right away instead. We maxed out for the facility management and may have not been able to meet his needs. During an interview on 3/20/25 at 1:14 p.m. medical doctor (MD) stated she had seen R1 at the facility during rounds on 3/7/25, and documented under the musculoskeletal section his right lower leg was clean, dry, no redness, swelling, approximately 3 cm in diameter, no tenderness, and no pus forming. He was placed on two antibiotics Doxycycline and Cephalexin, generally within 48 to 72 hours things should have started to improve. The nurse's documentation on 3/8/25 indicated a change in condition and she would have expected the nurse to have contacted a provider. R1 would have most likely been sent to ED sooner to determine if it were infected, and what to do next. During an interview on 3/20/25 at 2:09 p.m. RN-C	2 265		

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2 265	Continued From page 14 stated she had documented on 3/8/25 at 12:21 p.m. a skilled assessment in R1's progress notes. She had too much in her head and forgot to click yes on skin alterations and entered no instead. R1 had refused to have his legs looked at on 3/8/25, and the night staff nurse had told her his right lower leg looked swollen on the outer side. Staff nurses would be expected to contact the provider if there was a concern and/or abnormal assessment regarding his right lower leg. During an interview on 3/20/25 at 2:33 p.m. licensed practical nurse (LPN)-A stated she had documented on 3/7/25 at 5:01 a.m. a skilled assessment on R1 which identified a pressure ulcer on his buttocks and had not included the right lower leg wound. On 3/8/25, a nursing assistant (NA) informed me his right lower leg did not look good. He had an area that was blistered, refused to off load, and encouraged to elevate his legs and was new to her. She stated on 3/8/25 at 7:31 a.m. she had written a progress note: R1 had a boil or cysts looking mass to right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He had no to moderate complaints of pain in both right lower leg and left elbow. She was not sure if that would have been considered a change in condition for R1, vital signs were normal and not much pain. She stated she had gotten off track at times, had forgotten things, and should have contacted a provider when he had a change in condition, and made aware of what was going on with him. The skin on his right lower leg was tight, looked as though something was going to pop open, puffy like it was swollen, without pain. She was not aware he had a surgical wound but saw there was a dressing over it. Nursing staff were expected to have completed a skilled nursing assessment every shift and included a skin	2 265		

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2 265	Continued From page 15 assessment. She had entered R1 had a pressure ulcer in the clinical assessment and unsure if he had one. During an interview on 3/20/25 at 4:07 p.m. DON stated on 3/4/25, R1 was sent to ER, had fluid drained off his right lower leg, started on two antibiotics, a diagnosis of cellulitis, and sent back to facility on 3/5/25. On 3/8/25, the staff nurse should have called the provider when she noticed a change in R1's condition. Would have been important to get further direction and orders regarding sending him into ER. Mostly likely would have sent him in earlier. During an interview on 3/21/25 at 8:42 a.m. rehab director (PT) stated she had reported to nursing R1 complained of soreness in the right lower leg that was ongoing. On 3/3/25, his right lower extremity had a softball sized pocket of swelling, and she had taken him to the DON to have it assessed. Between 3/3/25 and 3/11/25, he had refused to walk due to pain in his right lower leg. On 3/11/25, she had reported he had refused to walk again. During an interview on 3/21/25 at 3:52 p.m. RN-D stated staff nurses were expected to complete a skilled assessment on R1 two times in a 24-hour period. She collected the information for the skilled assessment while in the room with the resident through observation/assessment, and vital signs. She documented a skill nursing assessment on 3/2/25, no pain, no skin issues. She had not recalled any skin issues. He had pain in the right lower leg and documented in error no pain. She was unable to recall if she had physically assessed/observed him during the 3/2/25, assessment. He returned from the hospital on 3/5/25, she completed a skilled	2 265		

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2 265	Continued From page 16 assessment and documented no edema or pain. She stated R1 had a hematoma, a localized bump, pain in right leg when touched or moved. Pain was not documented in her assessment. She documented a skilled nursing assessment on 3/10/25, no pain, no edema, and pressure ulcer buttocks. She stated it was a documentation error, no pressure ulcer identified. She had completed a skill nursing assessment earlier in the day on 3/11/25, and he had increased swelling in his right lower leg later that day when dressing was changed, and NP had seen him. Staff were expected to notify a provider as soon as possible if there was a change in condition so that the resident would have received the treatment they needed. Facility policy Weekly Skin Assessment and Documentation Process dated 1/20/23, identified skin ulcers and non-ulcers will be assessed and documented weekly by the facility wound nurse. When the nurse on the floor observes a new skin/wound alteration they should utilize the fax forms to notify the physician/nurse practitioner or call and put the new order in point click care (PCC). If a skin/wound alteration exhibits any decline or non-healing when the floor nurse is completing treatment or wound nurse is assessing, that nurse will notify the physician, document the decline and notification on the assessment form, and in the nurse's notes. The hot chart and care plan will be updated as appropriate. The nurse will notify the DON for further support and guidance. Facility policy Notification of Change in Resident Health Status dated 2/8/23, identified resident's physician and resident's legal representative will be notified of a change in resident status when the following occur:	2 265		

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2 265	Continued From page 17 a. A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications b. A need to alter treatment significantly, for example a need to discontinue an existing treatment due to adverse consequences, or to begin a new form of treatment, c. A decision to transfer or discharge the resident from the nursing home. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures to assure the resident's physician is notified of significant change in a resident's condition and/or the need to alter treatment and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		