

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 Therefore, the NATCEP prohibition is rescinded.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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 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 February 26, 2025, a survey was completed at your facility by the Minnesota Department of Health 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

Sterling Park Health Care Center

March 12, 2025

Page 2

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:

- 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 26, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by August 26, 2025 (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)

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>

Sterling Park Health Care Center

March 12, 2025

Page 4

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

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
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NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 2/25/25 through 2/26/25, 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.</p> <p>The following complaint was reviewed during the survey: H53758561C (MN110940) with a cited at F684.</p> <p>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.</p> <p>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.</p>	F 000		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered</p>	F 684		3/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/13/2025
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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 684	<p>Continued From page 1</p> <p>care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to implement treatment consistent to the resident's physician's orders and professional standards of practice, and revise interventions as appropriate for 1 of 3 residents (R1) when R1 was not sent sustenance with to his appointment.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 1/23/25, indicated R1 was admitted to the facility on 1/17/25, and R1 had diagnoses which included acute respiratory failure, pneumonia, and adult failure to thrive. Further, MDS identified R1 required substantial/maximal assistance with toileting hygiene and lower body dressing and R1 required supervision assistance with ambulation.</p> <p>R1's February 2025 Medication Administration Record (MAR) indicated R1 had an order for Osmolite (formula high in calories and protein to help patients gain and/or maintain healthy weight) 1.5 or equivalent formula, administer by Gtube (gastrostomy tube) with gravity flow four times a day related to malignant neoplasm of tongue. This administration was scheduled for 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. On 2/13/24 at 4:00 p.m., there was no evidence R1 received Osmolite as scheduled. On 2/20/25 at 11:00 a.m., R1's was documented as out of the facility without medications. R1's medical record lacked evidence of facility staff notifying R1's physician regarding the scheduled Osmolite when R1 had an appointment at the cancer center.</p> <p>R1's care plan as of 2/25/25, revealed R1 had an</p>	F 684	<ol style="list-style-type: none"> 1. In continuing compliance with F684, Resident Quality of Life, Sterling Park Healthcare Center corrected the deficiency by clarifying Dr orders on 3/6/2025 for R1 tube feeding for days R1 has extended appointment time. The facility currently has no other like residents on tube feeding. 2. To correct the deficiency and to ensure the problem does not recur the facility will educate all licensed nursing staff & appointment scheduler by March 24, 2025 regarding ensuring nutrition is addressed for any resident who has an extended appointment over meal times. 3. The DNS/or designee will audit beginning 03/24/2025 all appointments weekly for 4 weeks to ensure compliance with facility process. 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 2</p> <p>activities of daily living (ADL) self-care deficit and required staff assistance to use the toilet and with dressing. R1's care plan indicated R1 required tube feeding related to tongue cancer and need for supplemental tube feeding to meet nutritional needs and directed staff to administer tube feedings as ordered.</p> <p>R1's Progress Note dated 2/13/25, indicated registered nurse (RN)-A received a telephone call from R1's cancer center and the center reported R1 was incontinent at the center today and requested a bag be sent with R1 on infusion visits along with a change of clothes. In the future, facility will send clothes.</p> <p>R1's Nursing Note from the cancer center dated 2/20/25, indicated R1 presented to the cancer center as a two person assist (one to keep balance, one to clean resident) as resident was incontinent of urine four times and bowel once. R1 was unsteady on his feet throughout the day. Four new pairs of pants were given to R1 as well as one new shirt. R1 was not sent with any tube feedings or supplies to a 6-hour appointment.</p> <p>On 2/26/25 at 9:32 a.m., R1 was sitting in a recliner chair in his room watching television. R1 appeared to be comfortable and well groomed. R1 stated at times he was incontinent of urine and would notify staff to assist with changing brief and clothing. R1 stated he had appointments at the cancer center that lasted approximately 4 hours or longer each appointment, and R1 stated he does not get his tube feeding while at the appointments.</p> <p>On 9/26/25 at 10:36 a.m. RN-B stated R1 was independent with most of his ADLs like</p>	F 684		

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F 684	<p>Continued From page 3</p> <p>transferring and ambulation however R1 did require staff assistance for incontinence episodes. RN-B stated R1 had weekly appointments at the cancer center which required R1 to be out of the facility for most of the day, and RN-B stated she does not adjust his Osmolite administration times and RN-B had not consulted with R1's physician regarding adjusting the administration times for the days he was at the appointments. RN-B also confirmed she had never packed a bag for R1 to bring with his appointments with incontinent products or extra clothing.</p> <p>On 2/26/25 at 11:28 a.m., RN-A stated R1 required a tube feeding to ensure he was getting adequate nutrition and calorie intake due to being NPO (nothing by mouth). RN-A stated R1 had appointments at the cancer center that would take approximately 4 hours, and the facility was unable to send R1's Osmolite with to the appoint as the center can not manage the tube feeding. RN-A state the nurse from the cancer center had called her to report R1 had some incontinence episodes while at the appointment and had requested the facility pack a bag with incontinent products and extra clothes when R1 comes to future appointments. RN-A stated she had documented the request in R1's progress notes but was not sure if the information was communicated to other staff.</p> <p>On 2/26/25 at 12:04 p.m. nursing assistant (NA)-A stated R1 was independent with ADLs and would require minimal assistance by staff if R1 had an incontinent episode. NA-A was not aware of packing a bag for R1 when he would go out for appointments.</p>	F 684		

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F 684	<p>Continued From page 4</p> <p>On 2/26/25 at 12:46 p.m., an anonymous reporter (AR) stated R1 had appointments at the cancer center and at his appointment on 2/20/25, R1 was going to be at the center for over 6 hours and the facility staff did not send incontinence supplies, extra clothes, or administer his tube feeding. (AR) stated at the appointment R1 required the center's staff assistance with five incontinent episodes during his appointment. Further, AR was unsure how the cancer center was coordinating R1's care with the facility at this time, but stated communication occurred verbally by telephone with the facility most times. The cancer center had been in contact with facility staff prior to 2/20/25, regarding concerns they were having related to incontinent care and requesting staff to send R1 was the proper products to the appointments, however facility staff had not been following through.</p> <p>On 2/26/25 at 1:10 p.m., RN-C stated R1 was independent with ADLs and had incontinent episodes that may require staff assistance. RN-C stated R1 had appointment at the cancer center but was unsure how often his appointments were. RN-C stated the cancer center staff were not able to administer R1's tube feeding while at the appointment, so R1 would skip the tube feeding scheduled during the appointment and resume as scheduled when returning to the facility. RN-C confirmed she had not consulted with R1's physician about different options for the tube feeding schedule while R1 was at his appointment. Further, RN-C stated the cancer center was requesting facility staff to send extra incontinence products and clothes with R1 to his appointments, however RN-C did not revise R1's care plan or the nursing assistant's care guide sheets to include this.</p>	F 684		

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F 684	<p>Continued From page 5</p> <p>On 2/26/25 at 2:14 p.m., director of nursing (DON) stated R1 would leave the facility approximately around 9:30 a.m. for his appointments at the cancer center and return to the facility at approximately 2:00 p.m. DON stated she would expect staff to consult with R1's provider and attempt to stagger the tube feedings to ensure R1 received the ordered amount. The DON confirmed R1 had not received Osmolite on 2/13/25 or 2/20/25, but could not find a progress note as to why R1 did not receive the feeding or any notes consulting with R1's physician regarding not administering the Osmolite. The DON stated ensuring R1 received the ordered amount of Osmolite was important as this was R1's only nutrition right now. Staff were expected to send incontinent products and change of clothes with R1 to his appointment at the cancer center, and this was communicated to all staff on 2/13/24, by the 24-hour report. Care plans were expected to be revised by herself or RN-C, and DON confirmed R1's care plan lacked interventions and coordination of care for R1's chemotherapy appointments. In addition, staff were expected to coordinate resident's care with outside services by verbal updates.</p> <p>On 2/26/25 at 3:10 p.m., attempted interview with nurse practitioner (NP) -A was unsuccessful.</p> <p>On 2/26/25 at 4:06 p.m., DON stated she had not reviewed R1's Nursing Note from the cancer center dated 2/20/25,. The DON confirmed facility staff had not addressed the concerns from the cancer center.</p> <p>Requested facility policy for comprehensive care plans was requested but facility did not provide.</p>	F 684		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 12, 2025

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

Re: Event ID: W1L911

Dear Administrator:

The above facility survey was completed on February 26, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
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NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/25/25 through 2/26/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE 	(X6) DATE 03/13/25
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
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NAME OF PROVIDER OR SUPPLIER STERLING PARK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 142 NORTH FIRST STREET WAITE PARK, MN 56387
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>The following complaint was reviewed during the survey. H53758561C (MN110940).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		