Electronically delivered

February 13, 2020

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

RE: CCN: 245375
Cycle Start Date: January 9, 2020

Dear Administrator:

On January 23, 2020, we informed you that we may impose enforcement remedies.

On January 24, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 23, 2020, the situation of immediate jeopardy to potential health and safety cited at F0678 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 29, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 29, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 29, 2020.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Sterling Park Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 24, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230

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 July 9, 2020 (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:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 01/24/2020

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 1/22/20 through 1/24/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5375041C with deficiency cited at F678. The survey resulted in an immediate jeopardy at F678 which began on 1/10/20, when CPR was not provided by a CPR certified staff member, and non-emergency transportation was summoned instead of 911. The Administrator was notified of the IJ on 1/22/20 at 2:40 p.m. The immediate jeopardy was removed on 1/23/20. The above findings constituted substandard quality of care, and an extended survey was conducted from 1/22/20 through 1/24/20. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2020

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 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure competent staff implemented cardio-pulmonary resuscitation (CPR) and summoned emergency services in a timely manner for 1 of 1 resident reviewed who required CPR. This resulted in an immediate jeopardy (IJ) situation for R1, and had the potential to affect 7 of 7 other residents (R2, R3, R4, R5, R6, R7 and R8) who had identified a desire to receive CPR if their hearts should stop. . The immediate jeopardy began on 1/10/20, when CPR was not provided by a CPR certified staff member, and non-emergency transportation was summoned instead of 911. The Administrator was notified of the IJ on 1/22/20 at 2:40 p.m. The immediate jeopardy was removed on 1/23/20, but noncompliance remained at the lower scope and severity level of E, pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of the 2015 American Heart Association (AHA) professional guidelines indicated: If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious	F 678	1. Facility CPR guideline was revised on 1/22/20 to identify that only certified personnel can initiate CPR. 2. All full code like residents were reviewed. 3. Immediate re-education was provided to all nursing staff on 1/22/20 and 1/23/20 on the updated the CPR guideline, 911 emergency calls, physician order not required to send a resident to the Emergency Department and location of the CPR certification binder. 4. A CPR resource binder was created containing all current CPR certifications and will be kept in the central nursing station. The ED/Designee will audit the CPR resource binder monthly to ensure binder information is current. 5. The ED/Designee will audit weekly for one month and then monthly for three months to ensure continued compliance with staff on their knowledge of CPR guidelines, 911 emergency situation/calls and location of CPR resource binder.	2/23/20

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F 678	Continued From page 2 clinical signs of death (e.g. rigor mortis, dependent livid, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services (EMS) in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order. Review of a facility report to the State Agency dated 1/10/20, indicated R1 had been found on the floor next to her bed and did not respond to touch or verbal communication, but was breathing. The report indicated RN-A had called the on-call medical doctor (MD) and gotten a telephone order to send R1 to the hospital via ambulance. RN-A then called the ambulance. The notes indicated when the ambulance arrived they took over CPR and declared time of death at 12:40 a.m. On 1/10/20 nursing assistant (NA)-A informed the executive director (ED) and the director of nursing (DON) he had initiated CPR at the direction of registered nurse (RN)-A, but he was not CPR certified. The report indicated a facility investigation had been initiated, and it had been determined RN-A had directed a non-CPR certified NA to initiate CPR. In addition, the investigation revealed RN-A had left R1 with the NA during the incident on multiple occasions, and had called the non emergency number for ambulance transport instead of 911, and when asked by dispatch if they should come "regular" or "lights and sirens," RN-A had stated "regular," despite R1's full code status. This investigation lacked any additional information regarding the facility policy, or facility wide training. R1's 10/20/19, Directive to Define Scope of	F 678	6. As part of Sterling Park Health Care Center ongoing commitment to Quality Assurance, the Executive Director and/or designee, will report audit data through the communities QAPI Process so the Quality Assurance Committee can determine compliance and or needs for continued monitoring.	

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F 678	Continued From page 3 Medical Care identified R1's wishes were To Resuscitate which included full CPR. R1's current face sheet identified diagnoses of metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), sleep apnea, obesity, and chronic congestive heart failure. R1's 11/5/19, Care Area Assessment (CAA) identified R1 required extensive assistance of one to two staff for all activities of daily living (ADL's), and a brief interview for mental status (BIMS) indicated R1 had moderate cognitive impairment. R1's 11/5/19, care plan identified CPR for the code status and interventions included: observe and notify the medical practitioner of any changes in medical status, review code status quarterly and as needed, and spiritual care per request. R1's 1/10/20, progress notes identified at 11:45 p.m. last night, [R1] "was found on the floor sitting alongside her bed. Staff went in to assist [R1] off of the floor, but noticed [R1] was not responding to touch or verbal communication, but had a pulse and respirations with breathing present. [RN-A] called an on-call doctor at 11:50 p.m., and received a telephone order to send [R1] to hospital via ambulance. [RN-A] then called the ambulance to get a ride. Then staff alerted writer that resident went unresponsive at 11:55 p.m., and CPR was initiated. Staff and [RN-A] performed CPR until ambulance arrived. Ambulance arrived at 12:10 a.m., and the paramedics took over performing CPR. [RN-A] then called the family to notify them. At 12:40 a.m., the paramedics stopped performing CPR and declared time of death as 12:40 a.m., on 1/10/20."	F 678		

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F 678	Continued From page 4 During interview on 1/22/20 at 10:36 p.m., with the ED identified her expectation was that all licensed staff are certified in CPR and only the nurses should perform CPR. Our main concern was RN-A did not follow good practice. She should have been in control of the situation. When we were first notified that R1 passed away we did not have a concern until the next day when NA-A reported he was instructed by RN-A to perform CPR and was not certified. She further identified there had not been facility wide training after this incident and the facility did not have a policy related to emergency situations. Interview on 1/22/20 at 11:10 a.m., with NA-B identified he was certified in CPR and if directed by the nurse would initiate CPR and indicated there had been no facility wide training in the last month related to emergency situations or CPR. During interview on 1/22/20 at 11:16 a.m., LPN-A stated there had been no facility wide training regarding CPR or emergency situations in the last one month. During an interview with RN-B on 1/22/20 at 11:20 a.m., RN-B stated if she found a resident who had coded (not breathing/no pulse) she would do chest compressions then call 911. RN-B said she would have an NA initiate CPR if she knew they were CPR certified, and stated she would verify with the NA to make sure they were certified. RN-A further stated there had been no specific training regarding emergency situations or CPR provided. During an interview on 1/22/20 at 11:40 a.m., NA-A stated he had worked the evening shift on	F 678		

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F 678	Continued From page 5 1/9/20, and into the morning of 1/10/20. NA-A stated he had assisted R1 from her chair to her bed around 8:30-9:00 p.m. At approximately 11:40 p.m., R1 was found sitting on the floor next to her bed with her back against the bed. NA-A stated, initially R1 was breathing, but had stopped breathing so he immediately went and informed RN-A who had instructed him to start CPR. NA-A stated RN-A was making phone calls in the office trying to contact the physician. NA-A stated he ran back to R1's room and initiated CPR. He said he had been trained in CPR in 2012-2013 through Eagle Scouts (A Boy Scouts of America rank) by an online course. NA-A stated he was doing CPR without RN-A present as she was in and out of the room trying to make phone calls. Furthermore, NA-A stated he had received no additional training since that day, and did not know what he would do if this type of situation would happen again. NA-A stated he had reported the incident to the DON the following day, because he was concerned. During interview on 1/22/20 at 12:47 p.m., RN-A stated she had checked on R1 on 1/9/20, but was unaware of the time. RN-A stated she had found R1 sitting next to her bed. RN-A stated R1 had a pulse, respirations and was breathing stating, "It looked like she was sleeping." RN-A further stated, R1 would normally wake up when someone spoke to her, but R1 didn't respond. RN-A said she'd tried to shake her shoulder and call her name, then attempted a light sternal rub to see if that would wake her up. RN-A stated R1 had just grumbled at that time. RN-A then left R1 so she could call the on-call doctor for an order to send her to the hospital. RN-A had been told by other staff that if a resident was going to be sent to the hospital a doctor's order was required.	F 678		

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F 678	Continued From page 6	F 678		

RN-A said she'd received an order from the on-call physician, and had then called the non-emergency number for transportation to the hospital. RN-A said she was almost off the phone with the ambulance service when NA-A came into the nurses' office and informed her R1 had stopped breathing. RN-A said she'd told NA-A, "30 compression and 2 breaths." RN-A acknowledged she did not tell the ambulance dispatch that R1 had stopped breathing. RN-A also stated she'd thought all NA's had their CPR certification, but confirmed she had not asked NA-A if he was certified. RN-A said she took over CPR for NA-A until the ambulance arrived. RN-A also stated that following the incident, she'd received education including: a MD order is not needed for transport if it is an emergency, call 911 and not the non-emergency number, and CPR cannot be delegated to staff that are not certified. Furthermore, RN-A stated she did not feel properly trained for emergency situations, and stated she did not think there was a facility policy on what to do in emergency situations.

During an interview on 1/22/20 at 3:28 p.m., with family member (FM)-A, FM-A identified on 1/2/20 she had to shake R1 to wake her up stating, "She [R1] had been sleeping the last three days." FM-A stated she'd previously asked multiple times about R1 being sent to the hospital, but staff would tell her R1's vitals were normal. FM-A shared a voicemail RN-A had left on her phone 1/10/22 at 12:16 a.m: "We are doing CPR." 1/10/20 at 12:25 a.m., paramedics took over CPR.

The ambulance operational supervisor was interviewed on 1/23/20 at 10:54 a.m.. The ambulance operational supervisor stated the

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F 678	Continued From page 7	F 678		

ambulance crew had been dispatched routine, for a breathing resident that was a non-emergency call, just before midnight on 1/9/20.

Police officer (PO)-A was interviewed on 1/23/20 at 10:58 a.m. PO-A stated he was one of the officers arriving on the scene on 1/10/20. PO-A stated, the call first came over the radio as a lift assist, but when they got on scene there was a male staff member performing CPR. PO-A said when he and another police officer arrived, the staff left the room. "If the paramedics had questions we had to find the staff in an office about 100 feet away from [R1's] room. The staff members appeared discombobulated like they didn't know what to do in an emergency situation. The nurse was always on the phone when we went to ask questions in the office, and it was a struggle to get pertinent information. The staff were very concerned about getting [R1] back into bed after CPR had ceased."

Review of the 1/9 - 1/10/20 facility video surveillance of the hallway outside R1's room identified RN-A left the room multiple times during the emergency situation. RN-A was not present when NA-A initiated CPR at 12:07 a.m. After the CPR began, the video surveillance revealed RN-A was not in R1's room for approximately seven minutes. When the paramedics arrived at 12:16 a.m., the video initially showed them entering the facility with a gurney, then one paramedic left and returned with two bags. In addition, the surveillance video included:

-11:48 p.m., RN-A looked in R1's room, then came out of R1's room.
-11:49.58 p.m., NA-A entered R1's room.
-11:50.37 p.m., NA-A left R1's room.

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	245375	A. BUILDING _____ B. WING _____	C 01/24/2020

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

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F 678	Continued From page 8 -11:50.5 p.m., RN-A entered R1's room with the vital sign machine. -11:51.2 p.m., NA-A and NA-C out side of R1's room, RN-A left R1's room. -11:52.26 p.m., RN-A walked very slowly to R1's room and stood outside of the room talking on the phone and did not enter the room at this time stood outside. -11:52.53 p.m., RN-A walked away from R1's room. -11:58.05 p.m., RN-A entered R1's room. -11:59.17 p.m., RN-A left the room and was on the phone. -12:00 a.m., RN-A walked away from R1's room and was on the phone pacing up and down the hallway. -12:01 a.m., RN-A continued to walk around in the hallway by R1's room on the phone, but did not go in R1's room. -12:07.11 a.m., NA-A ran out of R1's room and then ran back to R1's room. -12:09 a.m., RN-A ran down the hall and entered R1's room. -12:09.27 a.m., RN-A left R1's room. -12:10.08 a.m., RN-A returned to R1's room. -12:11.37 a.m., RN-A left R1's room. -12:14.29 a.m., RN-A returned to R1's room. -12:16.30 a.m., RN-A left R1's room. -12:16.49 a.m., paramedics arrived to R1's room with the gurney. A police officer then radioed something. -12:17 a.m., RN-A stood outside of R1's room. One paramedic left R1's room. -12:18 a.m., the paramedic returned with two bags in his hands. During additional interview with RN-A on 1/23/20 at 3:37 p.m., RN-A stated the first phone call she'd made was to the DON, but the DON never	F 678		

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F 678	Continued From page 9	F 678		

answered, and then she called the on-call doctor for an order to transport R1.

During interview with the Medical Director and certified nurse practitioner (CNP) on 1/24/20 at 10:44 a.m., the Medical Director and CNP-A stated their expectation would be for the nurse (RN/LPN) to be in charge of the emergency situation. They stated for a resident who was unresponsive staff should have immediately called 911 if the resident was full code. The Medical Director stated, "The nurse should have told dispatch when the resident stopped breathing." CNP-A stated there had previously been no indication R1's death was imminent. The medical director stated, "A policy and procedure should be made available for staff in an emergency situations. It looks like we have some education to do here." Neither CNP-A or the medical director were aware that the family had previously requested R1 to be sent to the hospital.

During interview on 1/24/20 at 11:55 a.m., the ED (executive director) and the interim DON stated they had revised their CPR policy on 1/23/20. They stated the RN/LPN should supervise all emergency situations to ensure basic life support (BLS) was provided in a timely manner. The DON verified the RN should not have left the NA, and stated 911 should have been called immediately. The ED agreed with the interim DON's expectations.

Review of records for R2, R3, R4, R5, R6, R7 and R8 , revealed each of these residents had also expressed a desire to have CPR performed if their hearts would stop or they stopped breathing.

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F 678	Continued From page 10 Review of the facility's 12/2018 CPR policy, identified: If a resident experiences cardiac arrest, facility staff will provide basic life support, including CPR prior to the arrival of EMS (emergency medical services). The facility will provide adequately trained, 24 hour staffing to initiate basic life support within minutes of a resident's cardiac or respiratory arrest. A policy regarding emergency situations was requested, but the ED stated the facility did not have a policy for emergency situations. The IJ that began on 1/10/20, was removed on 1/23/20, when the facility had implemented a systemic plan of correction that included review of current policies and procedures, re-education of nursing staff to the facility's CPR Policy, re-education of staff about when to call 911, and to ensure staff were aware they did not need to contact a physician for an order to transfer during an emergency. Additionally, the facility established a system to verify staff competence for CPR implementation.	F 678		

Electronically delivered
February 13, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: LU9011

Dear Administrator:

The above facility was surveyed on January 22, 2020 through January 24, 2020 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.

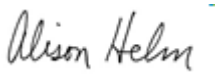
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230

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

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

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 1/22-1/24/20, surveyors of this Department's staff visited the above provider to investigate complaint H5375041C and the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using	2 000		

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2 000	Continued From page 1 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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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21810	Continued From page 2	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure competent staff implemented cardio-pulmonary resuscitation (CPR) and summoned emergency services in a timely manner for 1 of 1 resident reviewed who required CPR. This resulted in an immediate jeopardy (IJ) situation for R1, and had the potential to affect 7 of 7 other residents (R2, R3, R4, R5, R6, R7 and R8) who had identified a desire to receive CPR if their hearts should stop. Findings include: Review of the 2015 American Heart Association (AHA) professional guidelines indicated: If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of death (e.g. rigor mortis, dependent livid, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services (EMS) in accordance with the resident's advance directives	21810	Corrected	1/24/20

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21810	Continued From page 3 and any related physician order, such as code status, or in the absence of advance directives or a DNR order. Review of a facility report to the State Agency dated 1/10/20, indicated R1 had been found on the floor next to her bed and did not respond to touch or verbal communication, but was breathing. The report indicated RN-A had called the on-call medical doctor (MD) and gotten a telephone order to send R1 to the hospital via ambulance. RN-A then called the ambulance. The notes indicated when the ambulance arrived they took over CPR and declared time of death at 12:40 a.m. On 1/10/20 nursing assistant (NA)-A informed the executive director (ED) and the director of nursing (DON) he had initiated CPR at the direction of registered nurse (RN)-A, but he was not CPR certified. The report indicated a facility investigation had been initiated, and it had been determined RN-A had directed a non-CPR certified NA to initiate CPR. In addition, the investigation revealed RN-A had left R1 with the NA during the incident on multiple occasions, and had called the non emergency number for ambulance transport instead of 911, and when asked by dispatch if they should come "regular" or "lights and sirens," RN-A had stated "regular," despite R1's full code status. This investigation lacked any additional information regarding the facility policy, or facility wide training. R1's 10/20/19, Directive to Define Scope of Medical Care identified R1's wishes were To Resuscitate which included full CPR. R1's current face sheet identified diagnoses of metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), sleep apnea, obesity, and chronic congestive heart failure.	21810		

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21810	Continued From page 4 R1's 11/5/19, Care Area Assessment (CAA) identified R1 required extensive assistance of one to two staff for all activities of daily living (ADL's), and a brief interview for mental status (BIMS) indicated R1 had moderate cognitive impairment. R1's 11/5/19, care plan identified CPR for the code status and interventions included: observe and notify the medical practitioner of any changes in medical status, review code status quarterly and as needed, and spiritual care per request. R1's 1/10/20, progress notes identified at 11:45 p.m. last night, [R1] "was found on the floor sitting alongside her bed. Staff went in to assist [R1] off of the floor, but noticed [R1] was not responding to touch or verbal communication, but had a pulse and respirations with breathing present. [RN-A] called an on-call doctor at 11:50 p.m., and received a telephone order to send [R1] to hospital via ambulance. [RN-A] then called the ambulance to get a ride. Then staff alerted writer that resident went unresponsive at 11:55 p.m., and CPR was initiated. Staff and [RN-A] performed CPR until ambulance arrived. Ambulance arrived at 12:10 a.m., and the paramedics took over performing CPR. [RN-A] then called the family to notify them. At 12:40 a.m., the paramedics stopped performing CPR and declared time of death as 12:40 a.m., on 1/10/20." During interview on 1/22/20 at 10:36 p.m., with the ED identified her expectation was that all licensed staff are certified in CPR and only the nurses should perform CPR. Our main concern was RN-A did not follow good practice. She should have been in control of the situation. When we were first notified that R1 passed away	21810		

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21810	Continued From page 5	21810		

we did not have a concern until the next day when NA-A reported he was instructed by RN-A to perform CPR and was not certified. She further identified there had not been facility wide training after this incident and the facility did not have a policy related to emergency situations.

Interview on 1/22/20 at 11:10 a.m., with NA-B identified he was certified in CPR and if directed by the nurse would initiate CPR and indicated there had been no facility wide training in the last month related to emergency situations or CPR.

During interview on 1/22/20 at 11:16 a.m., LPN-A stated there had been no facility wide training regarding CPR or emergency situations in the last one month.

During an interview with RN-B on 1/22/20 at 11:20 a.m., RN-B stated if she found a resident who had coded (not breathing/no pulse) she would do chest compressions then call 911. RN-B said she would have an NA initiate CPR if she knew they were CPR certified, and stated she would verify with the NA to make sure they were certified. RN-A further stated there had been no specific training regarding emergency situations or CPR provided.

During an interview on 1/22/20 at 11:40 a.m., NA-A stated he had worked the evening shift on 1/9/20, and into the morning of 1/10/20. NA-A stated he had assisted R1 from her chair to her bed around 8:30-9:00 p.m. At approximately 11:40 p.m., R1 was found sitting on the floor next to her bed with her back against the bed. NA-A stated, initially R1 was breathing, but had stopped breathing so he immediately went and informed RN-A who had instructed him to start CPR. NA-A stated RN-A was making phone calls in the office

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21810	Continued From page 6	21810		

trying to contact the physician. NA-A stated he ran back to R1's room and initiated CPR. He said he had been trained in CPR in 2012-2013 through Eagle Scouts (A Boy Scouts of America rank) by an online course. NA-A stated he was doing CPR without RN-A present as she was in and out of the room trying to make phone calls. Furthermore, NA-A stated he had received no additional training since that day, and did not know what he would do if this type of situation would happen again. NA-A stated he had reported the incident to the DON the following day, because he was concerned.

During interview on 1/22/20 at 12:47 p.m., RN-A stated she had checked on R1 on 1/9/20, but was unaware of the time. RN-A stated she had found R1 sitting next to her bed. RN-A stated R1 had a pulse, respirations and was breathing stating, "It looked like she was sleeping." RN-A further stated, R1 would normally wake up when someone spoke to her, but R1 didn't respond. RN-A said she'd tried to shake her shoulder and call her name, then attempted a light sternal rub to see if that would wake her up. RN-A stated R1 had just grumbled at that time. RN-A then left R1 so she could call the on-call doctor for an order to send her to the hospital. RN-A had been told by other staff that if a resident was going to be sent to the hospital a doctor's order was required. RN-A said she'd received an order from the on-call physician, and had then called the non-emergency number for transportation to the hospital. RN-A said she was almost off the phone with the ambulance service when NA-A came into the nurses' office and informed her R1 had stopped breathing. RN-A said she'd told NA-A, "30 compression and 2 breaths." RN-A acknowledged she did not tell the ambulance dispatch that R1 had stopped breathing. RN-A

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also stated she'd thought all NA's had their CPR certification, but confirmed she had not asked NA-A if he was certified. RN-A said she took over CPR for NA-A until the ambulance arrived. RN-A also stated that following the incident, she'd received education including: a MD order is not needed for transport if it is an emergency, call 911 and not the non-emergency number, and CPR cannot be delegated to staff that are not certified. Furthermore, RN-A stated she did not feel properly trained for emergency situations, and stated she did not think there was a facility policy on what to do in emergency situations.

During an interview on 1/22/20 at 3:28 p.m., with family member (FM)-A, FM-A identified on 1/2/20 she had to shake R1 to wake her up stating, "She [R1] had been sleeping the last three days." FM-A stated she'd previously asked multiple times about R1 being sent to the hospital, but staff would tell her R1's vitals were normal. FM-A shared a voicemail RN-A had left on her phone 1/10/22 at 12:16 a.m: "We are doing CPR." 1/10/20 at 12:25 a.m., paramedics took over CPR.

The ambulance operational supervisor was interviewed on 1/23/20 at 10:54 a.m.. The ambulance operational supervisor stated the ambulance crew had been dispatched routine, for a breathing resident that was a non-emergency call, just before midnight on 1/9/20.

Police officer (PO)-A was interviewed on 1/23/20 at 10:58 a.m. PO-A stated he was one of the officers arriving on the scene on 1/10/20. PO-A stated, the call first came over the radio as a lift assist, but when they got on scene there was a male staff member performing CPR. PO-A said when he and another police officer arrived, the

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	00643	A. BUILDING: _____ B. WING _____	C 01/24/2020

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

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staff left the room. "If the paramedics had questions we had to find the staff in an office about 100 feet away from [R1's] room. The staff members appeared discombobulated like they didn't know what to do in an emergency situation. The nurse was always on the phone when we went to ask questions in the office, and it was a struggle to get pertinent information. The staff were very concerned about getting [R1] back into bed after CPR had ceased."

Review of the 1/9 - 1/10/20 facility video surveillance of the hallway outside R1's room identified RN-A left the room multiple times during the emergency situation. RN-A was not present when NA-A initiated CPR at 12:07 a.m. After the CPR began, the video surveillance revealed RN-A was not in R1's room for approximately seven minutes. When the paramedics arrived at 12:16 a.m., the video initially showed them entering the facility with a gurney, then one paramedic left and returned with two bags. In addition, the surveillance video included:

-11:48 p.m., RN-A looked in R1's room, then came out of R1's room.
-11:49.58 p.m., NA-A entered R1's room.
-11:50.37 p.m., NA-A left R1's room.
-11:50.5 p.m., RN-A entered R1's room with the vital sign machine.
-11:51.2 p.m., NA-A and NA-C out side of R1's room, RN-A left R1's room.
-11:52.26 p.m., RN-A walked very slowly to R1's room and stood outside of the room talking on the phone and did not enter the room at this time stood outside.
-11:52.53 p.m., RN-A walked away from R1's room.
-11:58.05 p.m., RN-A entered R1's room.
-11:59.17 p.m., RN-A left the room and was on

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the phone.
-12:00 a.m., RN-A walked away from R1's room and was on the phone pacing up and down the hallway.
-12:01 a.m., RN-A continued to walk around in the hallway by R1's room on the phone, but did not go in R1's room.
-12:07.11 a.m., NA-A ran out of R1's room and then ran back to R1's room.
-12:09 a.m., RN-A ran down the hall and entered R1's room.
-12:09.27 a.m., RN-A left R1's room.
-12:10.08 a.m., RN-A returned to R1's room.
-12:11.37 a.m., RN-A left R1's room.
-12:14.29 a.m., RN-A returned to R1's room.
-12:16.30 a.m., RN-A left R1's room.
-12:16.49 a.m., paramedics arrived to R1's room with the gurney. A police officer then radioed something.
-12:17 a.m., RN-A stood outside of R1's room. One paramedic left R1's room.
-12:18 a.m., the paramedic returned with two bags in his hands.

During additional interview with RN-A on 1/23/20 at 3:37 p.m., RN-A stated the first phone call she'd made was to the DON, but the DON never answered, and then she called the on-call doctor for an order to transport R1.

During interview with the Medical Director and certified nurse practitioner (CNP) on 1/24/20 at 10:44 a.m., the Medical Director and CNP-A stated their expectation would be for the nurse (RN/LPN) to be in charge of the emergency situation. They stated for a resident who was unresponsive staff should have immediately called 911 if the resident was full code. The Medical Director stated, "The nurse should have told dispatch when the resident stopped

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breathing." CNP-A stated there had previously been no indication R1's death was imminent. The medical director stated, "A policy and procedure should be made available for staff in an emergency situations. It looks like we have some education to do here." Neither CNP-A or the medical director were aware that the family had previously requested R1 to be sent to the hospital.

During interview on 1/24/20 at 11:55 a.m., the ED (executive director) and the interim DON stated they had revised their CPR policy on 1/23/20. They stated the RN/LPN should supervise all emergency situations to ensure basic life support (BLS) was provided in a timely manner. The DON verified the RN should not have left the NA, and stated 911 should have been called immediately. The ED agreed with the interim DON's expectations.

Review of records for R2, R3, R4, R5, R6, R7 and R8 , revealed each of these residents had expressed a desire to have CPR performed if their hearts would stop or they stopped breathing.

Review of the facility's 12/2018 CPR policy, identified: If a resident experiences cardiac arrest, facility staff will provide basic life support, including CPR prior to the arrival of EMS (emergency medical services). The facility will provide adequately trained, 24 hour staffing to initiate basic life support within minutes of a resident's cardiac or respiratory arrest.

A policy regarding emergency situations was requested, but the ED stated the facility did not have a policy for emergency situations.

SUGGESTED METHOD OF CORRECTION: The

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21810	Continued From page 11 director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents who want CPR receive the care in accordance with their wishes. The DON or designee could educate all appropriate staff to facility policies and procedures. The DON or designee could develop a monitoring system to verify there are staff trained in CPR working on each shift, to provide this care. The DON could monitor to ensure ongoing compliance, and could report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		