Electronically Delivered
June 14, 2021

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

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

Dear Administrator:

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

Feel free to contact me if you have questions.

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

Electronically delivered
May 7, 2021

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

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

Dear Administrator:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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

In addition, if substantial compliance with the regulations is not verified by October 26, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
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,

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

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 04/26/2021

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

(X4) 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 4/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5375047C (MN72133), with a deficiency cited at (F689). 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 689	F (F689)	5/24/21

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

Electronically Signed | 05/17/2021

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F 689	Continued From page 1 facility failed to comprehensively assess and develop interventions to provide adequate safety after a resident to resident verbal altercation for 2 of 3 residents reviewed (R1, R2), which resulted in a fall and in addition, a subsequent resident to resident physical altercation which had the potential to result in an additional fall. Findings include: R1's quarterly minimal data set (MDS) dated 1/25/21, indicated R1 had diagnoses that included dementia and Parkinson's disease. Further review of MDS, indicated R1 did not display behaviors and has had one fall with injury. R1's progress note dated 4/16/21, indicated R1 "was involved in a verbal altercation with another resident after dinner. Confusion over who was in control and possession of TV [television] remote. [R1] was instructed to inform staff, cannot walk over to another resident and attempt to remove item. Other resident moved to atrium to watch TV." Further review of R1's progress notes, dated 4/21/21, R1 and R2 had a physical altercation over the TV remote and staff immediately separated R1 and R2. R1's Progress notes reviewed from 4/16/21 through 4/26/21, did not address R1's fall due to altercation with R2 on 4/16/21. R1's care plan printed 4/26/21, indicated R1 was at risk for falls related to end stage Parkinson's with shuffled gait, dementia with poor safety awareness, and history of falls. Further review of care plan, indicated R1's last fall was on 2/20/21 in bathroom. However, R1's care place lacked evidence to address fall that occurred on 4/16/21,	F 689	PLAN OF CORRECTION 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 F 689 The facility will ensure all residents have an environment free of accident hazards as is possible and receive adequate supervision and assistance to prevent accidents. Sterling Park Healthcare Center corrected the deficiency by: ensuring R1 and R2 have care planned interventions to prevent verbal resident to resident altercations and, R1 has care planned fall prevention interventions. To ensure all like resident have appropriate interventions the facility has audited all incidents in the past 30 days to ensure appropriate interventions are in place. Completed by 5/24/2021. 2. To correct the deficiency and to ensure	

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F 689	Continued From page 2 and interventions were not added to prevent reoccurrence and injury. R2's progress note dated 4/16/21, indicated R2 "was observed having a verbal altercation with another resident [R1]. Writer observed resident [R1] attempting to grab the remote control away from R2. However, R2 would not let go off [of] the remote. After staff asked both resident[s] to stop grabbing on to the remote, R2 left the remote. As a result, the other resident [R1] lost his balance and fall [fell] on his buttock. Staff immediately, separated the two residents. R2 was directed to the atrium and utilize the other TV to watch his show where he settled for rest of shift." Facility report number 341538 dated 4/21/21, indicated R2 was watching TV in the dayroom and R1 ambulated over to R2 and began to argue over wanting the remote control for the TV. R1 attempted to remove the controller from R2's hand and R2 hit R1 on the head. Nursing assistant (NA)-A intervened and "caught" R1 "with her arms" so R1 "would not fall". During interview on 4/26/21, at 11:09 a.m. R1 stated "we [R1 and R2] pushed each other. I didn't get hurt. I tripped over someone's foot and fell down." During interview on 4/26/21, at 12:20 p.m. NA-A indicated an incident happened on 4/21/21, "right after supper. I saw R1 stood up and started walking up to R2. I walked up to them [R1 and R2] and said 'what's going on here?' They [R1 and R2] started yelling at each other. R2 then hit R1 on the neck. I was holding R1 because he has Parkinson's." NA-A then indicated the two residents were separated.	F 689	the problem does not recur all nursing staff will be reeducated on the facility accident/incident policy including reporting and documentation by the DON and/or designee. The DON and/or designee will audit all incidents weekly for 4 weeks and then randomly ongoing. Completed by 5/24/2021. 3. As part of Sterling Park Healthcare Center ongoing commitment to quality assurance, the DON and/or ED will report identified concerns through the community's QA Process.	

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F 689	Continued From page 3	F 689		

On 4/26/21, at 1:46 p.m. registered nurse (RN)-A indicated on 4/16/21, while RN-A was passing medications "out of the corner of my eye I saw R1 trying to grab the remote off R2. I told R2 to let go of the remote and he did. In the process R1 fell and got himself off [the floor] and no injuries were noted. I took R2 to the atrium. There was no physical contact made between them the only contact was with the remote."

On 4/26/21, at 2:15 p.m. director of nursing (DON) indicated she was made aware of the altercation that occurred on 4/21/21. For the incident on 4/16/21, DON indicated she was aware of a verbal altercation but she was not aware of R1 falling in result of the altercation.

On 4/26/21, at 2:42 p.m. RN-A indicated on 4/16/21, "R1 did fall and he basically got himself up, so I checked him to make sure he was ok and no injuries." RN-A then indicated RN-B "came over and took care of [R1] and I settled [R2] on the other side." Further, RN-A indicated "I think there was a misunderstanding RN-B was supposed to fill it [fall report] out, but it was not done. I am not sure if she [RN-B] knew there was a fall and she [RN-B] was supposed to do the report. It turns out there was not one, so I have to do one now, so I do not know whether she [RN-B] knew about it [fall] or not." RN-A then indicated "she [RN-B] was right there standing. I didn't tell her [RN-B] what happened. She [RN-B] didn't see the fall happen her [RN-B] back was facing the boys [R1 and R2]. RN-B knew the altercation happened I didn't tell [RN-B] about the fall. I just assumed [RN-B] knew about it so that is where the miscommunication is I think." In addition, when asked about the facility's fall protocol, RN-A

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F 689	Continued From page 4	F 689		

indicated "after a fall we [staff] do an incident fall report and we [staff] say what happened and what we [staff] have done about it. Also need to inform the DON." Further, RN-A confirmed interventions were not implemented following R1's fall and "that [R1] was RN-B's patient. The contributing factor was the fact that they [R1 and R2] were grabbing the remote from each other. The fact that I took R2 away was the intervention."

On 4/26/21, at 2:52 p.m. RN-B stated "I did not see him [R1] fall. R1 was already up and walking to the chair and I went and talked with R1." Further, RN-B stated "I did not know he fell and RN-A did not say anything. I don't know if she [RN-A] assumed I knew." In addition, RN-B stated "no interventions or incident report was made because I didn't know he fell. I did have a verbal conversation with R1 to not take it upon himself and get staff first. We [RN-A and RN-B] passed it [the altercation] on through report that R1 had an altercation with a resident" RN-B then indicated the altercation occurred on 4/16/21.

On 4/26/21, at 3:09 p.m. RN-C indicated RN-C was aware of the incident that occurred "last week" on 4/21/21, but was not aware "of an incident were R1 actually fell. I know there was an altercation where a staff actually caught R1 because R1 was pulling it [the remote] back and lost balance." In addition, when asked what the facility fall protocol was, RN-C stated "if a resident falls the nurse does a complete assessment and full assessment of limbs. Doctor, family, DON and administrator is called. The immediate interventions are implemented by the nurses involved at that time and then it is reviewed with the DON and myself in interdisciplinary team rounds and add more if needed." Further, RN-C

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F 689	Continued From page 5 stated "I don't recall a fall being discussed. I don't remember." On 4/26/21, at 3:17 p.m. when asked about the facility fall protocol, DON stated "if the resident is on the floor the nurse will assess the resident and use the hoyer to get the resident up. Very rarely does the resident jump up. I went down and talked with the nurse [RN-A] and she is implementing it into risk management now. If it is a fall without injury they [staff] update me through text message. Staff follow the fall process where they [staff] add details related to injuries, effect, witness actions taken, vitals and try to implement interventions to prevent it [fall] from happening again. It sounds like this is a miscommunication, however she [RN-A] is putting it in now." Facility document titled Fall Risk and Prevention Guidelines reviewed 1/21, indicated the purpose was "to ensure adequate interventions are in place to decrease, limit and prevent resident falls and ensure resident safety while maintaining their dignity and highest practical level of abilities." Further, facility document indicated post fall procedure included immediately assess and treat resident for injury, complete orthostatic blood pressures and vital signs, and make appropriate notifications. Facility document then directs staff to begin the root cause analysis and the nurse reviews the information collected to determine the root cause and initiates a plan based on the information. In addition, document indicated the plan of care is updated and revised with changes as indicated.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 58OK11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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:

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

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

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

Please feel free to call me with any questions.

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

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	00643	A. BUILDING: _____ B. WING _____	C 04/26/2021

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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 4/26/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5375047C (MN72133) with a licensing order issued at (1665). 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 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.	2 000		

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 04/26/2021

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21665	Continued From page 2	21665		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop interventions to provide adequate safety after a resident to resident verbal altercation for 2 of 3 residents reviewed (R1, R2), which resulted in a fall and in addition, a subsequent resident to resident physical altercation which had the potential to result in an additional fall. Findings include: R1's quarterly minimal data set (MDS) dated 1/25/21, indicated R1 had diagnoses that included dementia and Parkinson's disease. Further review of MDS, indicated R1 did not display behaviors and has had one fall with injury. R1's progress note dated 4/16/21, indicated R1 "was involved in a verbal altercation with another resident after dinner. Confusion over who was in control and possession of TV [television] remote. [R1] was instructed to inform staff, cannot walk over to another resident and attempt to remove item. Other resident moved to atrium to watch TV." Further review of R1's progress notes, dated 4/21/21, R1 and R2 had a physical altercation over the TV remote and staff immediately separated R1 and R2.	21665	F (F689) PLAN OF CORRECTION 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 F 689 The facility will ensure all residents have an environment free of accident hazards as is possible and receive adequate supervision and assistance to prevent accidents. Sterling Park Healthcare Center corrected the	5/24/21

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21665	Continued From page 3 R1's Progress notes reviewed from 4/16/21 through 4/26/21, did not address R1's fall due to altercation with R2 on 4/16/21. R1's care plan printed 4/26/21, indicated R1 was at risk for falls related to end stage Parkinson's with shuffled gait, dementia with poor safety awareness, and history of falls. Further review of care plan, indicated R1's last fall was on 2/20/21 in bathroom. However, R1's care place lacked evidence to address fall that occurred on 4/16/21, and interventions were not added to prevent reoccurrence and injury. R2's progress note dated 4/16/21, indicated R2 "was observed having a verbal altercation with another resident [R1]. Writer observed resident [R1] attempting to grab the remote control away from R2. However, R2 would not let go off [of] the remote. After staff asked both resident[s] to stop grabbing on to the remote, R2 left the remote. As a result, the other resident [R1] lost his balance and fall [fell] on his buttock. Staff immediately, separated the two residents. R2 was directed to the atrium and utilize the other TV to watch his show where he settled for rest of shift." Facility report number 341538 dated 4/21/21, indicated R2 was watching TV in the dayroom and R1 ambulated over to R2 and began to argue over wanting the remote control for the TV. R1 attempted to remove the controller from R2's hand and R2 hit R1 on the head. Nursing assistant (NA)-A intervened and "caught" R1 "with her arms" so R1 "would not fall". During interview on 4/26/21, at 11:09 a.m. R1 stated "we [R1 and R2] pushed each other. I didn't get hurt. I tripped over someone's foot and fell down."	21665	deficiency by: ensuring R1 and R2 have care planned interventions to prevent verbal resident to resident altercations and, R1 has care planned fall prevention interventions. To ensure all like resident have appropriate interventions the facility has audited all incidents in the past 30 days to ensure appropriate interventions are in place. Completed by 5/24/2021. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff will be reeducated on the facility accident/incident policy including reporting and documentation by the DON and/or designee. The DON and/or designee will audit all incidents weekly for 4 weeks and then randomly ongoing. Completed by 5/24/2021. 3. As part of Sterling Park Healthcare Center ongoing commitment to quality assurance, the DON and/or ED will report identified concerns through the community's QA Process.	

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21665	Continued From page 4 During interview on 4/26/21, at 12:20 p.m. NA-A indicated an incident happened on 4/21/21, "right after supper. I saw R1 stood up and started walking up to R2. I walked up to them [R1 and R2] and said 'what's going on here?' They [R1 and R2] started yelling at each other. R2 then hit R1 on the neck. I was holding R1 because he has Parkinson's." NA-A then indicated the two residents were separated. On 4/26/21, at 1:46 p.m. registered nurse (RN)-A indicated on 4/16/21, while RN-A was passing medications "out of the corner of my eye I saw R1 trying to grab the remote off R2. I told R2 to let go of the remote and he did. In the process R1 fell and got himself off [the floor] and no injuries were noted. I took R2 to the atrium. There was no physical contact made between them the only contact was with the remote." On 4/26/21, at 2:15 p.m. director of nursing (DON) indicated she was made aware of the altercation that occurred on 4/21/21. For the incident on 4/16/21, DON indicated she was aware of a verbal altercation but she was not aware of R1 falling in result of the altercation. On 4/26/21, at 2:42 p.m. RN-A indicated on 4/16/21, "R1 did fall and he basically got himself up, so I checked him to make sure he was ok and no injuries." RN-A then indicated RN-B "came over and took care of [R1] and I settled [R2] on the other side." Further, RN-A indicated "I think there was a misunderstanding RN-B was supposed to fill it [fall report] out, but it was not done. I am not sure if she [RN-B] knew there was a fall and she [RN-B] was supposed to do the report. It turns out there was not one, so I have to do one now, so I do not know whether she [RN-B]	21665		

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21665	Continued From page 5	21665		

knew about it [fall] or not." RN-A then indicated "she [RN-B] was right there standing. I didn't tell her [RN-B] what happened. She [RN-B] didn't see the fall happen her [RN-B] back was facing the boys [R1 and R2]. RN-B knew the altercation happened I didn't tell [RN-B] about the fall. I just assumed [RN-B] knew about it so that is where the miscommunication is I think." In addition, when asked about the facility's fall protocol, RN-A indicated "after a fall we [staff] do an incident fall report and we [staff] say what happened and what we [staff] have done about it. Also need to inform the DON." Further, RN-A confirmed interventions were not implemented following R1's fall and "that [R1] was RN-B's patient. The contributing factor was the fact that they [R1 and R2] were grabbing the remote from each other. The fact that I took R2 away was the intervention."

On 4/26/21, at 2:52 p.m. RN-B stated "I did not see him [R1] fall. R1 was already up and walking to the chair and I went and talked with R1." Further, RN-B stated "I did not know he fell and RN-A did not say anything. I don't know if she [RN-A] assumed I knew." In addition, RN-B stated "no interventions or incident report was made because I didn't know he fell. I did have a verbal conversation with R1 to not take it upon himself and get staff first. We [RN-A and RN-B] passed it [the altercation] on through report that R1 had an altercation with a resident" RN-B then indicated the altercation occurred on 4/16/21.

On 4/26/21, at 3:09 p.m. RN-C indicated RN-C was aware of the incident that occurred "last week" on 4/21/21, but was not aware "of an incident were R1 actually fell. I know there was an altercation where a staff actually caught R1 because R1 was pulling it [the remote] back and lost balance." In addition, when asked what the

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21665	Continued From page 6 facility fall protocol was, RN-C stated "if a resident falls the nurse does a complete assessment and full assessment of limbs. Doctor, family, DON and administrator is called. The immediate interventions are implemented by the nurses involved at that time and then it is reviewed with the DON and myself in interdisciplinary team rounds and add more if needed." Further, RN-C stated "I don't recall a fall being discussed. I don't remember." On 4/26/21, at 3:17 p.m. when asked about the facility fall protocol, DON stated "if the resident is on the floor the nurse will assess the resident and use the hoyer to get the resident up. Very rarely does the resident jump up. I went down and talked with the nurse [RN-A] and she is implementing it into risk management now. If it is a fall without injury they [staff] update me through text message. Staff follow the fall process where they [staff] add details related to injuries, effect, witness actions taken, vitals and try to implement interventions to prevent it [fall] from happening again. It sounds like this is a miscommunication, however she [RN-A] is putting it in now." Facility document titled Fall Risk and Prevention Guidelines reviewed 1/21, indicated the purpose was "to ensure adequate interventions are in place to decrease, limit and prevent resident falls and ensure resident safety while maintaining their dignity and highest practical level of abilities." Further, facility document indicated post fall procedure included immediately assess and treat resident for injury, complete orthostatic blood pressures and vital signs, and make appropriate notifications. Facility document then directs staff to begin the root cause analysis and the nurse reviews the information collected to determine the root cause and initiates a plan based on the	21665		

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21665	Continued From page 7 information. In addition, document indicated the plan of care is updated and revised with changes as indicated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures for fall protocol. The DON could provide training to all staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		