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	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Park Health Care Center	142 North First Street Waite Park, MN 56387

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to implement treatment consistent to the resident's physician's orders and professional standards of practice, and revise interventions as appropriate for 1 of 3 residents (R1) when R1 was not sent sustenance with to his appointment. Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 was admitted to the facility on [DATE], and R1 had diagnoses which included acute respiratory failure, pneumonia, and adult failure to thrive. Further, MDS identified R1 required substantial/maximal assistance with toileting hygiene and lower body dressing and R1 required supervision assistance with ambulation. R1's February 2025 Medication Administration Record (MAR) indicated R1 had an order for Osmolite (formula high in calories and protein to help patients gain and/or maintain healthy weight) 1.5 or equivalent formula, administer by Gtube (gastrostomy tube) with gravity flow four times a day related to malignant neoplasm of tongue. This administration was scheduled for 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. On 2/13/24 at 4:00 p.m., there was no evidence R1 received Osmolite as scheduled. On 2/20/25 at 11:00 a.m., R1's was documented as out of the facility without medications. R1's medical record lacked evidence of facility staff notifying R1's physician regarding the scheduled Osmolite when R1 had an appointment at the cancer center. R1's care plan as of 2/25/25, revealed R1 had an activities of daily living (ADL) self-care deficit and required staff assistance to use the toilet and with dressing. R1's care plan indicated R1 required tube feeding related to tongue cancer and need for supplemental tube feeding to meet nutritional needs and directed staff to administer tube feedings as ordered. R1's Progress Note dated 2/13/25, indicated registered nurse (RN)-A received a telephone call from R1's cancer center and the center reported R1 was incontinent at the center today and requested a bag be sent with R1 on infusion visits along with a change of clothes. In the future, facility will send clothes. R1's Nursing Note from the cancer center dated 2/20/25, indicated R1 presented to the cancer center as a two person assist (one to keep balance, one to clean resident) as resident was incontinent of urine four times and bowel once. R1 was unsteady on his feet throughout the day. Four new pairs of pants were given to R1 as well as one new shirt. R1 was not sent with any tube feedings or supplies to a 6-hour appointment. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 9:32 a.m., R1 was sitting in a recliner chair in his room watching television. R1 appeared to be comfortable and well groomed. R1 stated at times he was incontinent of urine and would notify staff to assist with changing brief and clothing. R1 stated he had appointments at the cancer center that lasted approximately 4 hours or longer each appointment, and R1 stated he does not get his tube feeding while at the appointments. On 9/26/25 at 10:36 a.m. RN-B stated R1 was independent with most of his ADLs like transferring and ambulation however R1 did require staff assistance for incontinence episodes. RN-B stated R1 had weekly appointments at the cancer center which required R1 to be out of the facility for most of the day, and RN-B stated she does not adjust his Osmolite administration times and RN-B had not consulted with R1's physician regarding adjusting the administration times for the days he was at the appointments. RN-B also confirmed she had never packed a bag for R1 to bring with his appointments with incontinent products or extra clothing. On 2/26/25 at 11:28 a.m., RN-A stated R1 required a tube feeding to ensure he was getting adequate nutrition and calorie intake due to being NPO (nothing by mouth). RN-A stated R1 had appointments at the cancer center that would take approximately 4 hours, and the facility was unable to send R1's Osmolite with to the appoint as the center can not manage the tube feeding. RN-A state the nurse from the cancer center had called her to report R1 had some incontinence episodes while at the appointment and had requested the facility pack a bag with incontinent products and extra clothes when R1 comes to future appointments. RN-A stated she had documented the request in R1's progress notes but was not sure if the information was communicated to other staff. On 2/26/25 at 12:04 p.m. nursing assistant (NA)-A stated R1 was independent with ADLs and would require minimal assistance by staff if R1 had an incontinent episode. NA-A was not aware of packing a bag for R1 when he would go out for appointments. On 2/26/25 at 12:46 p.m., an anonymous reporter (AR) stated R1 had appointments at the cancer center and at his appointment on 2/20/25, R1 was going to be at the center for over 6 hours and the facility staff did not send incontinence supplies, extra clothes, or administer his tube feeding. (AR) stated at the appointment R1 required the center's staff assistance with five incontinent episodes during his appointment. Further, AR was unsure how the cancer center was coordinating R1's care with the facility at this time, but stated communication occurred verbally by telephone with the facility most times. The cancer center had been in contact with facility staff prior to 2/20/25, regarding concerns they were having related to incontinent care and requesting staff to send R1 was the proper products to the appointments, however facility staff had not been following through. On 2/26/25 at 1:10 p.m., RN-C stated R1 was independent with ADLs and had incontinent episodes that may require staff assistance. RN-C stated R1 had appointment at the cancer center but was unsure how often his appointments were. RN-C stated the cancer center staff were not able to administer R1's tube feeding while at the appointment, so R1 would skip the tube feeding scheduled during the appointment and resume as scheduled when returning to the facility. RN-C confirmed she had not consulted with R1's physician about different options for the tube feeding schedule while R1 was at his appointment. Further, RN-C stated the cancer center was requesting facility staff to send extra incontinence products and clothes with R1 to his appointments, however RN-C did not revise R1's care plan or the nursing assistant's care guide sheets to include this. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 2:14 p.m., director of nursing (DON) stated R1 would leave the facility approximately around 9:30 a.m. for his appointments at the cancer center and return to the facility at approximately 2:00 p.m. DON stated she would expect staff to consult with R1's provider and attempt to stagger the tube feedings to ensure R1 received the ordered amount. The DON confirmed R1 had not received Osmolite on 2/13/25 or 2/20/25, but could not find a progress note as to why R1 did not receive the feeding or any notes consulting with R1's physician regarding not administering the Osmolite. The DON stated ensuring R1 received the ordered amount of Osmolite was important as this was R1's only nutrition right now. Staff were expected to send incontinent products and change of clothes with R1 to his appointment at the cancer center, and this was communicated to all staff on 2/13/24, by the 24-hour report. Care plans were expected to be revised by herself or RN-C, and DON confirmed R1's care plan lacked interventions and coordination of care for R1's chemotherapy appointments. In addition, staff were expected to coordinate resident's care with outside services by verbal updates. On 2/26/25 at 3:10 p.m., attempted interview with nurse practitioner (NP) -A was unsuccessful. On 2/26/25 at 4:06 p.m., DON stated she had not reviewed R1's Nursing Note from the cancer center dated 2/20/25,. The DON confirmed facility staff had not addressed the concerns from the cancer center. Requested facility policy for comprehensive care plans was requested but facility did not provide.