Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	03/20/2025

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a right lower leg abscess worsened and required hospitalization . Findings include: R1's admission Minimum Data Set, dated dated dated [DATE], identified intact cognition without behaviors. He had a functional impairment of the upper extremities located on one side, used a walker, and a motorized wheelchair for mobility. He required substantial/maximal assistance for personal/toilet hygiene, dressing, bathing, partial/moderate assistance lying to sit, sit to stand, and all transfers. Ambulation was not attempted due to medical conditions or safety concerns. Medical diagnoses included peripheral vascular disease (PVD) (arteries became narrowed or blocked, reduced blood flow to extremities, most often feet and legs), cerebrovascular accident (CVA) (stroke), hemiplegia/hemiparesis (significant weakness or paralysis in one half of the body), and at risk for pressure ulcers. R1's care plan dated 3/6/25, identified he had an activities of daily living (ADL) self-care performance deficit related to CVA and weakness from acute illness. Staff were directed to report any changes in skin such as redness and bruising to nurse and observe/document/report to medical practitioner as needed (PRN) any changes in medical status, reasons for self-care deficit, expected course, and decline in function. He had potential for pressure injury development related to Braden scale (a tool used to assess the risk for developing pressure ulcers) score 13-14 (moderate risk) and surgical incision to right lower extremity (RLE). Staff were directed to administer treatments as ordered and observe for effectiveness, observe dressing to ensure it was intact, properly placed, report loose dressing to the nurse, stress the importance of frequent repositioning, and notification to family and medical provider of any new area of skin breakdown or worsening in status of current area. R1's progress notes from 3/1/25 through 3/4/25, identified: -3/1/25 at 5:54 p.m. Skilled Charting -Skin/wound integrity alterations: yes and no, moisture associated skin damage on buttocks. Treatments: application of ointments/creams/medications. No edema or pain. -3/2/25 at 11:31 a.m. Complained of right lower extremity pain 7 out of 10, refused Tylenol. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/2/25 at 12:36 p.m. Received acetaminophen 500 milligrams (mg) orally for generalized pain in right leg. -3/2/25 at 1:22 p.m. Acetaminophen was effective. -3/2/25 at 1:50 p.m. Skilled Charting -Skin/wound integrity alterations: none. No edema or pain. -3/3/25 at 8:08 a.m. physical therapy (PT) service notes: R1 began therapy session via exercises on lower extremities. He was asked to complete the right lower extremity exercises, he stated he was unable to, due to pain 7 out of 10. PT assistant lifted his pant leg and saw a softball sized pocket of swelling on the mid-calf. PT brought him to director of nursing (DON) for assessment and requested no further lower extremity exercise or mobility until further assessed. -3/3/25 at 10:42 a.m. Right lower leg: pain 7/10, very tender and hot to touch, taut, 22 centimeters (cm) x 11 cm x 4 cm of a bulge coming out of the lower right side of leg, unable to move his leg or walk, winces and groans/moans when he tried to move his leg. Pain radiated up leg to top of knee. Provider notified phone call (PC), spoke to nurse, she was going to notify nurse practitioner (NP) and return PC back with direction/orders. -3/3/25 at 11:13 a.m. New orders per NP: ultrasound (US) RLE diagnosis (DX) swelling and rule out (r/o) deep vein thrombosis (DVT) (blood clot) and doxycycline 100 mg by mouth (po) two times a day (BID) times seven days. DON was aware. -3/3/25 at 12:24 p.m. Phone call to schedule US per order, they will call with estimated time of arrival to complete US. -3/3/25 at 5:48 p.m. Orders- administration note: Initial that pain was observed every shift. Document any verbal and/or non-verbal indicators of pain and interventions, including non pharmalogical interventions in pain progress note, two times a day. Severe pain noted, right lower edema, provider notified, US on RLE this evening at 5:00 p.m. -3/4/25 at 9:11 a.m. Electronic medication administration record (EMAR): Resident received Tylenol 500 mg orally for pain rated 7 out of 10. -3/4/25 at 12:32 p.m. Per NP, send R1 to emergency room (ER) for RLE. He agreed, consent for bed hold received. He signed form and emergency medical system (EMS) transported to local hospital at 12:50 p.m. -3/4/25 at 12:49 p.m. R1 was sent to ER due to suspected infection of the lower extremity. -3/4/25 at 3:39 p.m. PT service notes: He reported high pain in the right lower extremity with softball sized swelling on the mid-calf. Nursing updated and NP here to see pt today. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's ER/hospital after visit summary dated 3/4/25, Reason for visit: cellulitis. Diagnoses: Hematoma and cellulitis of the right lower extremity. Instructions: The large lump on the outside of the right leg is a hematoma. We have concerned [sic] that hematoma which is a collection of old blood likely previous trauma is may [sic] infected. Please take the antibiotics as prescribed and return if you are having increasing right leg pain, swelling, fevers. Call your doctor now or seek immediate medical care if: you have signs your infection is getting worse such as: increased pain, new or worse swelling, warmth, or redness, red streaks leading from the area, pus draining from the area, a fever, or you get a rash. R1's progress notes from 3/5/25 through 3/11/25, identified: -3/5/25 at 7:47 a.m. Per ER visit with a diagnosis of hematoma (a collection of blood outside of blood vessels that can form in any part of the body from ruptured blood vessels that cause symptoms such as swelling, bruising, and pain)/cellulitis (a common bacterial infection of the skin and underlying tissue and causes redness, swelling, pain and warmth in the affected area) of the right lower extremity. Labs basic metabolic panel (BMP) (measures several key substances in the body including electrolytes, blood sugar, kidney function, and liver function), c-reactive protein (a protein produced by the liver in response to inflammation), an incision and drain was performed. Dressing clean, dry, and intact (CDI). -3/5/25 at 4:24 p.m. Non-pressure Ulcer/injury assessment: initial assessment completed on new area a surgical wound, measured length 0.7 cm, width 0.2 cm, and depth 0. Peri wound: bloody drainage noted surrounding skin warm and pink hued, no odor present. Doctor was notified of new skin condition on 3/4/25. New wound, seen inER on [DATE] and area was lanced to allow for drainage. -3/5/25 at 6:41 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatment: non-sterile dressing changes. No edema or pain. -3/6/25 at 8:09 a.m. PT service notes: he continued to have pain in RLE which limited his range of motion (ROM), standing, and ambulation. Nursing was aware of RLE pain. -3/6/25 at 10:04 a.m. Acetaminophen 500 mg administered for complaints of mild pain in right leg and rated pain at 6 out of 10. -3/6/25 at 11:55 a.m. Administration of acetaminophen was effective pain at 3 out of 10. -3/6/25 at 3:05 p.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-sterile dressing changes. No edema or pain. -3/6/25 at 3:07 p.m. Body audit completed. Alternations in skin integrity identified: Right lower leg (front) hematoma and small incision was drained at local hospital. Fingernails and toenails clean and trimmed. Inspection of heels indicated firm. Edema in lower extremities noted. -3/7/25 at 11:59 a.m. he was hesitant to work on standing, declined attempts to walk, refused to bear full weight on RLE, and had increased soreness during weight shifting, and remained limited by the pain. Nursing was aware of his RLE pain and monitored the swelling. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/7/25 at 12:00 a.m. Regulatory visit by medical doctor (MD): . musculoskeletal exam: right lower leg showed a firm mass about 3 cm in diameter with a central incision which was clean, dry and no drainage. Lesion was not fluctuant (did not feel soft or squishy like a fluid-filled area but instead felt firm/solid), was not warm, red, or tender. -3/7/25 at 5:01 p.m. Skilled Charting -Skin/wound integrity alterations: pressure ulcer on buttocks. Treatments: cream. No edema or pain. -3/7/25 at 8:42 a.m. Acetaminophen 500 mg administered for pain 5 out of 10. -3/7/25 at 11:25 a.m. Follow up pain 6/10, administration of acetaminophen: ineffective. -3/7/25 at 5:21 p.m. Administration of acetaminophen 500 mg for pain 7 out of 10. -3/7/25 at 8:30 p.m. Follow up pain 0/0, was effective. -3/8/25 at 7:18 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer, location unidentified. Treatments: cream. Edema, yes, 2 plus (+) moderate pitting, indentation subsided rapidly. No pain. -3/8/25 at 7:21 a.m. He had a boil or cysts looking mass to the right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He complained of moderate to no pain in both right leg and left elbow. He had sat for house on wheelchair without elevating his legs. The resident was encouraged to ask for help in elevating his feet. -3/8/25 at 8:23 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/35 at 9:24 a.m. Follow up pain 7 out of 10, was ineffective. -3/8/25 at 12:21 p.m. Skilled Charting -Skin wound integrity alterations: no. Edema, yes, 1+ mild pitting, slight indention, no perceptible swelling of the leg. No pain. -3/8/25 at 4:43 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/8/25 at 7:36 p.m. Follow up pain 0 out of 10, was effective. -3/9/25 at 5:41 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. -3/9/25 at 8:36 a.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/9/25 at 11:24 a.m. Follow up pain 5 out of 10, was effective. -3/9/25 at 12:25 p.m. Skilled Charting -Skin wound integrity alterations: yes, other, right leg swollen. Treatments, none. Edema, yes, 1+ mild pitting, slight indentation, no perceptible swelling of the leg. -3/9/25 at 4:36 p.m. Acetaminophen 500 mg administered for pain for pain 7 out of 10. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/9/25 at 8:41 p.m. Follow up pain: unknown. -3/10/25 at 3:33 a.m. Skilled Charting -Skin wound integrity alterations: yes, pressure ulcer. Treatments: cream. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/10/25 at 10:12 p.m. Acetaminophen 500 mg administered for pain 7 out of 10. -3/10/25 at 1:37 p.m. Follow up pain 0 out of 10, was effective. -3/10/25 at 5:26 p.m. Skilled Charting -Skin/wound integrity alterations: yes, pressure ulcers/buttocks, and hematoma to right calf. Treatments cream and non-surgical dressing changes. No edema or pain. -3/11/25 at 12:00 a.m. Provider update/visit: re-evaluation of his right lower leg. Appeared worse than visit one week ago when he was set to ER, incision and drainage (I & D) was attempted for abscess. Doxycycline and Cephalexin for seven days. Today right lower leg increased in size, warm, and redness. Denies fever or chills. Continues to appear a pocket of fluid collection left lateral aspect of leg down to ankle. Therapy reporting difficulty standing, weight bearing which is new for him. He is agreeable to ER evaluation for worsening abscess related to (r/o) osteomyelitis (infection of the bone). Signed by NP on 3/11/25 at 12:18 p. m. -3/11/25 at 6:03 a.m. Skilled Charting -Skin/wound integrity alterations: yes, hematoma to right leg. Treatments: non-surgical dressing change. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. -3/11/25 at 7:39 a.m. Acetaminophen 500 mg administered . resident complained of severe moderate pain on his right leg, rated his pain at 7 out of 10. -3/11/25 at 9:21 a.m. Follow up pain 4 out of 10, was effective. -3/11/25 at 11:38 a.m. Occupational therapy (OT) notes: he stood for two minutes times three then declined working on any functional reaching tasks due to RLE pain 5 out of 10. -3/11/25 at 2:58 p.m. NP looked at resident's wound and was warm to touch . he was sent to ER for evaluation. -3/11/25 at 5:12 p.m. Skilled Charting -Skin/wound integrity alterations, yes hematoma to right leg, warm to touch, increased swelling. Sent to ER for evaluation. Treatments: non-surgical dressing change. Edema present 2+ moderate, pitting, indentation subsides rapidly. No pain. -3/11/25 at 6:59 p.m. Resident's right lower leg assessed by NP today at on-site visit. His wound was warm to touch and had increased swelling. Pain to touch and with movement on 4 to 6/10. No drainage noted. NP recommended resident be sent to ER for evaluation. Resident went to ER via non-emergent transport around 12:00 p.m. -3/11/25 at 11:56 p.m. Nurse called local hospital for follow-up; resident was admitted with cellulitis. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Emergency department (ED) to hospital admission 3/11/25 through 3/14/25, identified discharge diagnoses: right distal lower extremity hematoma. Hospital course: presented toER on [DATE] with right leg discomfort and swelling. He had been recently seen inER on [DATE] with right leg pain and swelling and at that time had an elevated leukocytosis (white blood cells indicated infection). An incision and drainage (I&D) were performed for suspicion of abscess and infected hematoma of the right leg but appeared to be more of an old hematoma. There was some concern for cellulitis so was placed on a course of two antibiotics, Doxycycline and Keflex then discharged . He reported right leg pain and enlargement for one week. A magnetic resource imaging (MRI) of right calf was completed and showed heterogeneous (appeared uniformity in texture or composition) mass in the subcutaneous aspect of the lateral calf which appeared most consistent with hematoma. Ultimately was felt that it was a hematoma and there was no infection. Orthopedics recommended a heat and ice compression. Physical exam identified a 5 cm by 4 cm area of swelling and fluctuance (subject to change, variable, or capable of being moved or compressed) in the lateral aspect of his distal right lower extremity. No warm or redness noted. R1's progress notes from 3/14/25 through 3/15/25, identified: -3/14/25 at 3:23 p.m. Resident readmitted to facility after being hospitalized . diagnosis: hematoma of the right calf. -3/15/25 at 12:29 p.m. Skilled Charting -Skin wound integrity alterations: yes, hematoma to right leg, warm to touch, increased swelling resolving. Treatments: non-surgical dressing changes. Edema, yes, 2+ moderate pitting, indentation subsided rapidly. No pain. During an interview on 3/20/25 at 10:18 a.m. registered nurse (RN)-A stated R1 was admitted to the facility beginning of February 2025 with respiratory and cardiac issues. She saw him on 2/26/25 and 2/27/25 and was not aware of any skin concerns at that time. On 3/5/25 he returned from the hospital, staff would be expected to assess his right lower leg wound and dressing, complete daily dressing changes, assessments, and document. On 3/8/25 the staff nurse should have contacted the provider and updated them regarding a change in condition. He was already on an antibiotic but may had needed to go to ER and could have possibly avoided another visit. During an interview on 3/20/25 at 11:21 a.m. RN-B started she had seen R1 on 3/5/25 when he returned to facility from the hospital. She removed the dressing located on his right lower leg and noted bloody drainage without odor. She cleaned the wound with normal saline, completed the weekly non-pressure ulcer/injury assessment and applied a dressing. The floor nurses were responsible to monitor it and update her if there were changes. On 3/8/25 the staff nurse charted there was a change in condition and a provider should have been notified and updated to see what steps should have been taken next. R1 did not have a pressure ulcer but had been documented by staff nurses he did. The skilled assessments were completed and used to show a change in condition. A provider could have reached 24/7 and communicated with via email. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/25 at 11:57 p.m. nurse practitioner (NP) stated R1 was sent toER on [DATE] and diagnosed with cellulitis and started on antibiotics. MD saw him on 3/7/25. She saw him on 3/11/25, and his right lower leg was much redder, swollen, hot to the touch, and did not look any better than when she saw him on 3/4/25. There was fluid collection noted and she would empower the nursing staff to have updated and let the provider know. She had not been contacted from 3/5/25 to 3/11/25 with any concerns or change in condition. Staff would have been expected to complete a daily dressing change, skin assessments/monitoring of the wound, and error on the side of caution. He could have had osteomyelitis and possible sepsis, had taken antibiotics for two days with no improvement, should have been sent in right away instead. We maxed out for the facility management and may have not been able to meet his needs. During an interview on 3/20/25 at 1:14 p.m. medical doctor (MD) stated she had seen R1 at the facility during rounds on 3/7/25, and documented under the musculoskeletal section his right lower leg was clean, dry, no redness, swelling, approximately 3 cm in diameter, no tenderness, and no pus forming. He was placed on two antibiotics Doxycycline and Cephalexin, generally within 48 to 72 hours things should have started to improve. The nurse's documentation on 3/8/25 indicated a change in condition and she would have expected the nurse to have contacted a provider. R1 would have most likely been sent to ED sooner to determine if it were infected, and what to do next. During an interview on 3/20/25 at 2:09 p.m. RN-C stated she had documented on 3/8/25 at 12:21 p.m. a skilled assessment in R1's progress notes. She had too much in her head and forgot to click yes on skin alterations and entered no instead. R1 had refused to have his legs looked at on 3/8/25, and the night staff nurse had told her his right lower leg looked swollen on the outer side. Staff nurses would be expected to contact the provider if there was a concern and/or abnormal assessment regarding his right lower leg. During an interview on 3/20/25 at 2:33 p.m. licensed practical nurse (LPN)-A stated she had documented on 3/7/25 at 5:01 a.m. a skilled assessment on R1 which identified a pressure ulcer on his buttocks and had not included the right lower leg wound. On 3/8/25, a nursing assistant (NA) informed me his right lower leg did not look good. He had an area that was blistered, refused to off load, and encouraged to elevate his legs and was new to her. She stated on 3/8/25 at 7:31 a.m. she had written a progress note: R1 had a boil or cysts looking mass to right lower leg and left elbow. It was warm to touch and looked as though it was forming pus. He had no to moderate complaints of pain in both right lower leg and left elbow. She was not sure if that would have been considered a change in condition for R1, vital signs were normal and not much pain. She stated she had gotten off track at times, had forgotten things, and should have contacted a provider when he had a change in condition, and made aware of what was going on with him. The skin on his right lower leg was tight, looked as though something was going to pop open, puffy like it was swollen, without pain. She was not aware he had a surgical wound but saw there was a dressing over it. Nursing staff were expected to have completed a skilled nursing assessment every shift and included a skin assessment. She had entered R1 had a pressure ulcer in the clinical assessment and unsure if he had one. During an interview on 3/20/25 at 4:07 p.m. DON stated on 3/4/25, R1 was sent to ER, had fluid drained off his right lower leg, started on two antibiotics, a diagnosis of cellulitis, and sent back to facility on 3/5/25. On 3/8/25, the staff nurse should have called the provider when she noticed a change in R1's condition. Would have been important to get further direction and orders regarding sending him into ER. Mostly likely would have sent him in earlier. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 8:42 a.m. rehab director (PT) stated she had reported to nursing R1 complained of soreness in the right lower leg that was ongoing. On 3/3/25, his right lower extremity had a softball sized pocket of swelling, and she had taken him to the DON to have it assessed. Between 3/3/25 and 3/11/25, he had refused to walk due to pain in his right lower leg. On 3/11/25, she had reported he had refused to walk again. During an interview on 3/21/25 at 3:52 p.m. RN-D stated staff nurses were expected to complete a skilled assessment on R1 two times in a 24-hour period. She collected the information for the skilled assessment while in the room with the resident through observation/assessment, and vital signs. She documented a skill nursing assessment on 3/2/25, no pain, no skin issues. She had not recalled any skin issues. He had pain in the right lower leg and documented in error no pain. She was unable to recall if she had physically assessed/observed him during the 3/2/25, assessment. He returned from the hospital on 3/5/25, she completed a skilled assessment and documented no edema or pain. She stated R1 had a hematoma, a localized bump, pain in right leg when touched or moved. Pain was not documented in her assessment. She documented a skilled nursing assessment on 3/10/25, no pain, no edema, and pressure ulcer buttocks. She stated it was a documentation error, no pressure ulcer identified. She had completed a skill nursing assessment earlier in the day on 3/11/25, and he had increased swelling in his right lower leg later that day when dressing was changed, and NP had seen him. Staff were expected to notify a provider as soon as possible if there was a change in condition so that the resident would have received the treatment they needed. Facility policy Weekly Skin Assessment and Documentation Process dated 1/20/23, identified skin ulcers and non-ulcers will be assessed and documented weekly by the facility wound nurse. When the nurse on the floor observes a new skin/wound alteration they should utilize the fax forms to notify the physician/nurse practitioner or call and put the new order in point click care (PCC). If a skin/wound alteration exhibits any decline or non-healing when the floor nurse is completing treatment or wound nurse is assessing, that nurse will notify the physician, document the decline and notification on the assessment form, and in the nurse's notes. The hot chart and care plan will be updated as appropriate. The nurse will notify the DON for further support and guidance. Facility policy Notification of Change in Resident Health Status dated 2/8/23, identified resident's physician and resident's legal representative will be notified of a change in resident status when the following occur: a. A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications b. A need to alter treatment significantly, for example a need to discontinue an existing treatment due to adverse consequences, or to begin a new form of treatment, c. A decision to transfer or discharge the resident from the nursing home.