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	05/02/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation, interview and document review, the facility failed to assess residents for the ability to self-administer medications after staff set up, or obtain order for medication self-administration for 1 of 1 (R27) residents observed self-administering medication. Findings include: R27's significant change of condition Minimum Data Set (MDS) dated [DATE], indicated R27's brief interview for mental status (BIMS) revealed a score of 15 indicating R27 was cognitively intact. The MDS indicated R27 took high risk medications which included opioids (strong pain-relieving medicines) and anti-platelet medications (medications that prevent blood clots from forming). R27's diagnoses included atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), peripheral vascular disease (PVD-a blood circulation disorder) and renal insufficiency, renal failure, or end stage renal disease (poor function of the kidneys). R27's order summary report for active orders as of 5/1/24 lacked an order to self-administer medication after staff set up. During observation on 4/29/24 at 06:07 p.m., R27 was seated in his room eating. R27 reached behind him to the nightstand and picked up a white medication cup with an undisclosed number of pills in it and proceeded to dump pills into his mouth, took several sips of water and then continued to eat his meal. R27 could not identify the pills he had taken, nor how long they had been on the bedside table. R27 stated staff brought pills in and left them on the bedside table all the time. R27 denied staff stayed to verify he had taken the medications. During interview on 4/29/24 at 07:45 p.m., trained medication aide (TMA)-A stated R27 had three medications scheduled at 5 p.m. which included a vitamin, acetaminophen and Vascepa (a medication that reduces the risk of heart attack, stroke and other heart problems). TMA-A stated staff would sometimes leave the meds in the room with R27 because 'we know he is really good about taking them'. TMA-A stated R27 would require an order to self-administer medications that are set up by staff and left at the bedside to take independently. TMA-A acknowledged that R27 did not have an order to self-administer medication. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview 5/1/24 at 12:28 p.m., registered nurse charge nurse (RN)-CN stated a medication self-administration assessment would need to be completed if a resident was requesting meds to be left at bedside to be taken independently after staff set up. RN-CN confirmed there was not a medication self-administration assessment completed for R27. During interview on 5/1/24, at 01:10 p.m., registered nurse case manager (RN)-CM stated all residents needed a self-administration assessment before staff can leave meds at the bedside to have resident self-administer. RN-CM acknowledged R27 did not have a self-administration assessment, or an order from the physician to self-administer medications. Director of nursing (DON) was not available for interview. Facility document medication administration-general guidelines, section B -Administration indicated medications are administered in accordance with written orders of the prescriber; medications are administered at the time they are prepared; medications are not pre-poured either in advance of the med pass; the person who prepares the dose for administration is the person who administers the dose; and , residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. Facility document preparation and general guidelines with subtitle of self- administration of medications, indicated if a resident desired to self-administer medications, an assessment is conducted by the interdisciplinary team of the residents cognitive (including orientation of time), physical, and visual ability to carry out this responsibility during the care planning process.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49654

Based on interview and document review the facility failed to ensure adequate and required information was documented and communicated to a receiving healthcare facility to ensure continuity of care when transferred emergently to a hospital setting for 1 of 1 residents (R38) reviewed for hospitalization s.

Findings include:

R38 was admitted to the facility on [DATE] after a brief hospitalization .

R38's care plan included diagnoses of essential hypertension (high blood pressure), hyperlipidemia (too many fats in your blood), chronic kidney disease stage 3, major depressive disorder, anxiety, and type 1 diabetes mellitus. Additionally, R38 required assistance with dressing, set up for eating, assist of two with toileting, assistance of one staff for bed mobility, required pressure relieving support in bed and in wheelchair, and used a mechanical lift with assistance of two staff for all transfers.

R38's minimum data set (MDS) 5-day assessment dated [DATE] indicated R38 had intact cognition, adequate hearing with use of hearing aids, was dependent on staff for toileting needs, bathing and dressing, was dependent for all bed mobility and transfers, was dependent on staff for ambulation with wheelchair, and was incontinent of bowel and bladder.

Nursing progress notes dated 2/25/24 between 21:22 p.m. and 22:04 p.m., indicated R38 reported feeling nauseous, did not eat supper and was not drinking fluids. R38 was given four mg Zofran (a medication used to prevent nausea and vomiting) per standing orders. Progress notes also indicated R38 had one episode of vomiting.

Progress note dated 2/26/24 at 01:59 a.m. indicated R38 was noted to have moist non-productive cough and was placed on supplemental oxygen of 1 liter per minute via nasal cannula. Progress note with same date at 17:28 p.m. labeled as late entry indicated R38 was sent to emergency room .

Review of the medical record lacked sufficient documentation that a notice of transfer had been provided and/or communication to receiving hospital including physician caring for R38, emergency contact information, and relevant information including (usual physical/mental functioning, advance directive, diagnosis, allergies, medication administration record (MAR), treatment administration record (TAR), care plan, discharge summary, and any special instructions).

During interview on 5/1/24 at 11:30 a.m. trained medication aide (TMA)-B stated the process for sending a resident to the emergency room would include getting an order from the provider, updating the family and document in the electronic medical record (EMR) the reason a resident is sent out.

(continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/24 at 11:48 a.m., registered nurse case manager (RN)-CM stated she could not locate any information in R38's EMR the reason why R38 was transferred to emergency room , nor any documentation of communication with provider and receiving hospital. (RN)-CM stated there should be more information available in the EMR. During interview on 5/2/24 at 12:01 p.m. registered nurse clinical reimbursement specialist (RN)-CRS stated there wasn't enough documentation in the EMR to say why R38 had been sent to the emergency room . (RN)-CRS stated staff didn't follow the process to transfer someone out and 'it leaves a lot of questions unanswered'. Document titled Notice of Transfer/Discharge Process with updated date of 10/22/20201 indicated residents and the resident's representative would be given a Notice of Transfer for any transfer to acute care, an emergency department (ED), or involuntary transfer or discharge from the community. The notice would be given prior to or within 48 hours of discharge or transfer from the community. Furthermore, the process included the notice would be in writing, provided on a facility approved form and would include reason for transfer and effective date and time of transfer or discharge, and a copy placed in resident's medical record. Additionally, an accompanying bed hold should go along with the resident at time of discharge or transfer. Review of residents electronic and paper medical record lacked any documentation of notice of transfer had been completed or given to R38.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and document review, the facility failed to ensure 1 of 1 residents (R38), or legal representative had been informed of bed hold rights at the time of hospitalization . Findings include: R38's minimum data set (MDS) 5-day assessment dated [DATE] indicated R38 had intact cognition. R38's progress note dated 2/26/24 at 17:28 p.m. indicated R38 was sent to emergency room . Review of R38's medical record identified no documentation of a bed hold notification had been provided to R38 or her son who was her emergency contact. Progress note dated 2/27/24 at 09:20 a.m. indicated R38's son was notified R38 had been sent to the emergency room the prior evening. No mention of a bed hold was documented. During interview on 5/2/24 at 11:48 a.m. registered nurse case manager (RN)-CM stated a bed hold form should be sent with residents at time of transfer or family should be notified and advised of the bed hold. (RN)-CM indicated she could not locate any documentation in R38's medical record that a bed hold had been completed for R38. During interview on 5/2/24 at 12:01 p.m. registered nurse clinical reimbursement specialist (RN)-CRS stated R38's medical record lacked documentation regarding a bed hold. (RN)-CRS stated staff didn't follow the process to transfer someone out and 'it leaves a lot of questions unanswered' and the medical was missing some key information and paperwork. Document titled Notice of Transfer/Discharge Process with updated date of 10/22/2021 indicated residents and the resident's representative would be given a Notice of Transfer for any transfer to acute care, an emergency department (ED), or involuntary transfer or discharge from the community. The notice would be given prior to or within 48 hours of discharge or transfer from the community. Furthermore, the process included the notice would be in writing, provided on a facility approved form and would include reason for transfer and effective date and time of transfer or discharge, and a copy placed in resident's medical record. Additionally, an accompanying bed hold should go along with the resident at time of discharge or transfer. Review of residents electronic and paper medical record lacked any documentation of notice of transfer had been completed or given to R38.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation, interview, and documentation review the facility failed to ensure coordination of care and communication between the facility and the dialysis center for 1 of 1 resident (R27) receiving hemodialysis. Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 diagnoses included atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), peripheral vascular disease (PVD-a blood circulation disorder) and renal insufficiency, renal failure, or end stage renal disease (ESRD) (poor function of the kidneys), and dependence on renal dialysis. Additionally, the MDS indicated R27's brief interview of mental status (BIMS) score was 15 indicating R27 was cognitively intact. During interview on 4/29/24, at 05:57 p.m., R27 stated he attended dialysis three times per week 'somewhere in St Cloud'. R27's order summary report with an active orders as of 05/01/24, indicated R27 had dialysis scheduled every Tuesday, Thursday, and Saturday at dialysis center. R27's treatment sheet schedule for April 2024 indicated R27 received dialysis every Tuesday, Thursday and Saturday; had pre/post assessments completed by facility staff documented in R27's electronic medical record (EMR); instructions to notify director of nursing (DON) if no paperwork was received from dialysis center upon R27's return. Pre and post assessments were documented in EMR as completed for entire month of April 2024. Review of R27's record lacked a dialysis care plan, nor did it include the name, address, and phone number of the dialysis center where R27 was receiving dialysis. During interview on 05/01/24, at 08:00 a.m., with dialysis center registered nurse (RN)-DC, stated the dialysis center did not send paperwork back with patients if they did not come with paperwork and R27 'never has any paperwork'. RN-DC stated if a resident received new orders from a dialysis physician, they would fax the order to the resident's facility. Additionally, if a provider from a facility wrote new orders, 'it would be nice to see that for our providers' but dialysis RN-DC again stated R27 never arrived with paperwork from his facility. During interview on 5/1/24, at 01:10 p.m., registered nurse case manager (RN)-CM confirmed R27 was currently receiving dialysis at an outside facility. RN-CM stated she did not see any dialysis communication documents either scanned nor in R27's hard chart. RN-CM stated this should be obtained by the floor nurses when R27 returns from dialysis. During interview on 5/1/24 at 11:30 a.m., trained medication aide (TMA)-B stated papers were never sent with R27 or received from the dialysis facility when he went to and returned from dialysis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/2024, at 04:22 p.m., registered nurse clinical reimbursement specialist (RN)-CRS confirmed R27 was listed as receiving dialysis three times per week. RN-CRS clinical reimbursement specialist could not locate any clinical communication either to or from the dialysis center. DON was not available for interview. Facility document with subject of Dialysis care plan and treatment sheet with an effective date of 2/2019 indicated dialysis patients should have a dialysis care plan that included the name of the dialysis location with the phone number, and the days the resident is scheduled to receive dialysis. A request for a copy of contract with the dialysis center was requested but was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49654 Based on observation, interview and record review, the facility failed to ensure medications were available to be administered as prescribed by the physician, for 1 of 1 residents (R27) reviewed for medication. Findings include: Physician progress note dated 4/16/24 indicated R27's diagnoses included atherosclerotic heart disease of native coronary artery (a condition where arteries become narrowed and hardened), diabetes mellitus type II, chronic A-fib (irregular heart rate), and end stage renal failure. Additionally it indicated R27 had orders to take Vascepa (a medication that is used to reduce the risk of heart attack or stroke) oral capsule one Gm (Icosapent Ethyl) give two capsules by mouth two times a day for hypertriglyceridemia. R27's progress notes and medication administration record revealed the following missed doses of Vascepa: 4/21/24 PM dose, 4/22/24 AM and PM dose, 4/23/24 AM and PM dose, 4/24/24 AM and PM dose, 4/25/24 AM and PM dose, 4/26/24 AM and PM dose, 4/27/24 AM and PM dose, 4/28/24 AM and PM dose, 4/29/24 AM and PM dose, 4/30/24 AM and PM dose totaling 19 doses in April 2024. During interview on 5/1/24 at 08:17 a.m., pharmacy technician (PHT)-A reviewed pharmacy documentation for the month of April and reported no documentation of communication via fax or calls from the facility regarding the missing medication. PHT-A stated R27 received all of his medications via this pharmacy. During interview on 05/01/24 at 11:30 a.m., with trained medication aide (TMA)-B stated when medications needed to be ordered a sticker is removed from the medication card and placed on a pharmacy order form and faxed to the pharmacy. TMA-B stated if the medication was not available for multiple days it should be documented in the electronic medical record (EMR), the med room would be checked, the registered nurse charge nurse (RN)-CN updated to reorder it, the pharmacy would be called, and the resident would be updated. If the medication continued to be unavailable for multiple shifts TMA-B stated she would ask RN-CN to contact pharmacy and to notify the physician. TMA-B stated sometimes the RN-CN would let staff know why the med wasn't available, and typically the RN-CN would update the director of nursing (DON). TMA-B stated she did not know why R27's medication had not been delivered. During interview on 5/1/24 at 12:28 p.m., (RN)-CN stated medications were ordered using a requisition form from the pharmacy and placing a sticker with the requested medication on the form to be faxed to the pharmacy. RN-CN stated sometimes it would be faxed multiple times a day for several days and would frequently get an error message on the fax machine indicating a busy line. RN-CN stated she did not update the provider if a medication was unavailable but rather updated the registered nurse case manager. RN-CN stated she thought the provider would be notified after three days. RN-CN stated ordering medications was completed as a team effort. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 01:10 p.m., registered nurse case manager (RN)-CM stated if a mediation was unavailable, she would check to see if a request had been faxed or if the pharmacy had been contacted. RN-CM stated the provider should have been notified early in the process when R27 was missing medication doses, as early as one day of missed doses. During interview on 5/1/24 at 01:23 p.m. and 02:00 p.m., administrator stated if there was issues with pharmacy, she would contact the head of the pharmacy directly. Administrator stated she was unaware R27 had missed medication doses. After this surveyor informed administrator about the missing medication, administrator indicated she had instructed staff to go back into the electronic medical record and document every attempt made to reach the pharmacy. Additionally, administrator stated a change in payer source for the resident was a primary reason why a medication wasn't sent. Administrator reported a call back from pharmacy that indicated R27 had a payer change, and this subsequently disrupted the cycle of medication being filled by the pharmacy. Administrator stated she expected the provider, as well as herself, to be notified if pharmacy issues had occurred. During interview on 5/1/24 at 02:33 p.m., R27 nurse practitioner (NP)-1 stated she had been in frequent contact with the facility and had been in the facility on three separate occasions since the first missed dose on 4/21/24 but was not notified R27 had missed doses or medication was unavailable. NP-1 stated her expectation was to be notified after the first missed dose, or the first day if the medication is taken twice per day so she could assist in resolving the missed medication issues. Document titled Medication Ordering and Receiving From Pharmacy, subtitled ordering and receiving non-controlled medications from the dispensing pharmacy with a revision date of 11/18 indicated the following: If not automatically refilled by pharmacy, repeat medications (refills) are ordered as follows-reordering of medications is done in accordance with the order and delivery schedule developed by the pharmacy provider. Quantities of medications sent from the pharmacy may vary in accordance with payer status, insurance plan, or law. Reorder medication several days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Base on observation, interview, and document review, the facility failed to store and label food properly, dispose of undated and expired food items, to reduce the risk of food borne illness. This deficient practice had the potential to affect 34 residents who were provided meals from the kitchen. Findings include: During initial tour of kitchen on [DATE], at 11:33 a.m., with dietary manager (DM) the following was observed: - in the room with the serving window, on the back wall was a three door free standing cooler. Behind the first door was two plastic serving cups of jello uncovered/undated, three plastic serving cups of fruit cocktail uncovered/undated. Behind the third door a meal that had been saved had no label of when it was placed in the cooler. - in the room with the serving window, next to the three door cooler stacked on the floor were three racks of hamburger and hotdog buns. DM stated these were outdated and needed to be returned to the bread company. There was no signage indicating to staff to not use the bread products and return to the bread company. - in the middle sink of a three-sink system, two bags of frozen fish which had been cut or torn open across the top were placed in a large metal steam dish, set in sink and had water running over and into the plastic bag containing the fish.Water was observed splashing against the sink, and back into the open containers of fish. - in dry storage area, a large open bag of breadcrumbs was noted. DM stated these were not to be used and acknowledged lacked signage directing staff to not use them. Two bags of dark chocolate chips were open, and the open end loosely rolled down and placed on shelf. There was no label indicating when opened, and bag was not adequately sealed. - in walk in cooler one open box of grated parmesan cheese was held closed with a black clip. No label indicating date opened. One large box labeled as Activities held strawberries, cheese and other covered items. No items in the box were labeled with date opened or use by dates. On the top left shelf closest to the walk-in freezer door, three apple pies were loosely covered with plastic wrap but lacked a label indicating date put in cooler and use by date. Three- and one-half logs of hamburger were observed in an uncovered plastic bin. DM stated she was unclear how long they had been there and indicated they had completely thawed out. The hamburger logs had no opened date and no use by date was noted. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- in walk-in freezer, ice was built up around the door and across the threshold and three-fourths of the way up the right side of the door. Upon opening the door, DM looked inside the freezer, observed the items on the floor and open items frozen to the shelf and stated, 'this is really bad'. Just inside the door on the top shelf was a pile of light colored food in open bags that could not be identified. The items had frozen to the shelf and could not be easily removed. One case of chopped spinach, one case of hamburger patties, one case of french fries, one case of salisbury steak, two cases of country veggie blend and one case of biscuit dough were located directly on the floor of the walk-in freezer. - in the food preparation area, a roll out cart containing three bins: the front bin had a sealed plastic cover and labeled as flour; the second bin was loosely covered with plastic wrap but was not securely attached leaving an open area on the back approximately one inch. DM identified this as sugar and stated we have to get a new cover that fits. The third bin had a sealed plastic cover and was labeled flour. During second tour of kitchen on [DATE], at 05:02 p.m., the following observations were made: - in the three-door cooler, behind first door four cups of fruit cocktail with no label identifying open date or use by date were observed. - walk-cooler ice/frost was observed across threshold and up the right side of the freezer door approximately 12 inches. Inside freezer placed directly on the floor were the following: one case broccoli, one case white shrimp, two cases pumpkin pies, one case breaded chicken pieces, and two cases beef sirloin. During interview on [DATE], at 12:27 p.m., DM stated all food in any cooler or refrigerator must be covered and labeled with date opened to avoid potential food borne illnesses. DM acknowledged that staff was not labeling food appropriately, if at all and stated staff had been trained on the proper way to store food in the coolers and freezer to include rotating stock to use oldest items first, labeling any open products with date opened, no items stored directly on the floor, checking dates on open products and removing outdated items from coolers and freezers daily. During interview with administrator on [DATE] at 01:23 administrator stated the kitchen staff was contracted staff and not regular employees. Additionally, administrator stated she expected the DM to keep things running smoothly in the kitchen. A policy regarding food storage was requested but not provided.

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F 0883

Level of Harm - Potential for minimal harm

Residents Affected - Many

Develop and implement policies and procedures for flu and pneumonia vaccinations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49654

Based on interview and document review, the facility failed to offer or provide the pneumococcal vaccine for 1 of 5 (R26) residents reviewed for immunizations.

Findings include:

The CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23, indicated adults aged [AGE] years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to [AGE] years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old.

R26's Admission Minimum Data set (MDS), dated [DATE], indicated intact cognition, had a diagnoses to included congestive heart failure, diabetes, and hypertension.

R26's face sheet indicated R26 birthday was 7/4/1949

R26's immunization form in the electronic medical record (EMR) indicated R26 received Prevnar 13 on 12/514, Pneumo-PPSV23 on 10/28/02, 10/18/13 and 12/7/18. Additionally, the EMR indicated R26 wasn't eligible to receive the PCV20 vaccine until 12/2024. This was outside the CDC recommendation of five years after last dose of Pneumo-PPSV23. Based on CDC guidance R26 had been eligible to receive PCV20 vaccine beginning 12/7/23. Furthermore, R26's EMR lacked evidence that R26 was provided education, offered, or received the PCV20 vaccination.

During interview on 4/30/24, at 03:39 p.m., with director of nursing who was also the infection preventionist (DON) stated upon acceptance of a referral to the facility, a central admissions nurse uploaded all pertinent information into the facilities EMR, including immunization records obtained from hospital records or Minnesota immunization information connection (MIIC). DON stated the facility followed CDC recommendations for pneumococcal vaccinations and utilized a CDC based tool that would track eligible residents and indicated the date they were eligible to receive recommended vaccines. DON stated ideally a newly admitted resident who was eligible to receive a vaccine would see the provider on the next rounding date and the facility would request orders to administer the vaccine at that visit. Additionally, DON stated that monthly audits were performed to catch eligible residents. DON stated based on review of R26's EMR and facility policy which reportedly followed CDC guidance and recommendations, R26 was not eligible to receive the PCV20 until 12/2024.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

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 0883 Level of Harm - Potential for minimal harm Residents Affected - Many	A policy, Pneumococcal Vaccinations, with updated date of 4/1/2024 indicated all residents will be provided with the opportunity and encouraged to receive pneumococcal vaccinations; and revaccination of pneumococcal vaccine will be re-evaluated every six years.