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	08/01/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow process to ensure advanced directives were accurately documented and updated on the resident's electronic health record (EHR) banner, physician orders and Physician's Orders for Life Saving Treatment (POLST) which affected 2 of 16 residents (R35 and R19) reviewed for advance directives. These findings constituted an immediate jeopardy (IJ) situation for R35 and R19 who would not have received cardiopulmonary resuscitation measures (CPR) according to their wishes. The IJ began on [DATE], when R35's POLST, indicating R35's wishes for resuscitation was signed by the medical provider and it was not changed within the facility's EHR to reflect R35's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care staff outlined they would implement the incorrect directions and not perform CPR which was against R35's wishes due to this error. The director of nursing (DON) was notified of the IJ on [DATE] at 5:55 p.m. The IJ was removed on [DATE] at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. The director of nursing (DON) was notified of the IJ on [DATE] at 5:55 p.m. The IJ was removed on [DATE] at 10:56 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm.Findings include: R35's quarterly Minimum Data Set (MDS) dated [DATE], identified R35 had intact cognition and required assistance with all activities of daily living (ADL)'s. R35's diagnoses included acute on chronic systolic (congestive) heart failure, hypertension, renal failure, diabetes mellitus, and chronic respiratory failure with hypoxia. R35's electronic health record (EHR) banner reviewed on [DATE] at 4:18 p.m., identified R35 was do not resuscitate/do not intubate (DNR/DNI). R35's Order Summary report dated [DATE], indicated DNR/DNI status. R35's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse’s station, signed by R35 and medical doctor (MD)-A on [DATE] indicated full code status. During interview on [DATE] at 3:02 p.m., trained medication aide (TMA)-A stated she would refer to the banner in the EHR, in the event of an emergency, regarding resident’s code status. TMA-A confirmed R35’s code status stated DNR/DNI. TMA-A stated they would take no action, except to notify the nurse, in the event R35 was without breath or heartbeat. According to information noted in R35's EHR, TMA-A stated they would alert the nurse R35 was do not resuscitate/do not intubate. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. Building B. Wing	08/01/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 3:04 p.m., nursing assistant (NA)-A stated she would refer to the banner on the computer or tablet regarding resident’s code status. During interview on [DATE] at 4:29 p.m., R35 stated if her heart stopped, she would want cardiopulmonary resuscitation (CPR) to resuscitate her. During interview on [DATE] at 4:31 p.m., director of nursing (DON) stated her expectations would be for staff to look at the emergency red binder located in the nurse’s station in the event of an emergency at the actual signed POLST for code status. If code status orders do not match, there would be a high risk of initiating the wrong life-saving treatments. DON looked at POLST that was in the emergency red binder and confirmed code status was changed to full code on [DATE] and was signed by both R35 and the provider. DON then confirmed the banner and order in the EHR stated code status as DNR/DNI and the order date on it was [DATE]. DON confirmed the providers order from [DATE] had gotten missed and that R35 would not have received CPR in the event of an emergency. R19’s R19's admission Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition and required assistance with all activities of daily living (ADL)'s. R19's diagnoses included type II diabetes mellitus (DM) with polyneuropathy, hypothyroidism, hypertension, and chronic kidney disease stage 3. R19's electronic health record (EHR) banner reviewed on [DATE] at 3:20 p.m., identified R19 was do not resuscitate (DNR). R19's Order Summary report dated [DATE], indicated DNR status. R19's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the emergency binder in the nurse’s station, signed by R19 on [DATE] indicated full code status. R19’s Directives to Define Scope of Medical Care form, signed by R19 and dated [DATE], indicated TO RESUSCITATE. Both forms were signed by certified nurse practitioner (CNP)-A on [DATE] and were scanned into R19’s EHR. During interview on [DATE] at 3:00 p.m., R19 stated she wanted cardiopulmonary resuscitation (CPR) to be performed if necessary, but she did not “want all the tubes and stuff. During interview on [DATE] at 3:03 p.m., licensed practical nurse (LPN)-B stated she would refer to the banner in the EHR, in the event of an emergency. If she did not have access, she would look in the binder kept in the nurses charting room. LPN-B accessed PCC and confirmed R19’s banner indicated DNR. LPN-B stated if there was a discrepancy she would call the residents family member or power of attorney if they had one to determine the residents wishes. LPN-B stated, if R19's heart stopped or R19 stopped breathing, she would not initiated CPR as directions in PCC were DNR. (continued on next page)

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	08/01/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 3:57 p.m., Director of Nursing (DON) stated during the admission process they completed an initial form named Directives to Define Scope of Medical Care, indicating the residents wishes and code status. That form was temporary, until the medical provider comes in and the completes the POLST form with the resident and/or Power of Attorney (POA). Once the POLST was completed it was scanned into the EHR and then placed in the red binders at the nurse’s station. The Case Manager was responsible for obtaining orders signed by the medical provider and entering the order into the residents EHR which pulled into the banner. DON stated if there were a discrepancy the care staff know to use the POLST/binder. DON stated she felt the orders should be double checked by another nurse. DON stated CNP-A was usually good about telling them if there was a change, and the residents code status was also supposed to be reviewed with the resident and/or family during care conferences quarterly and annually and this was handled by the social worker. DON stated her expectation in the event of a medical emergency, was for staff to go directly to the red POLST binder, rather than trying to log in to the EHR. If there were a discrepancy there would not have been time to call a POA for clarification. DON stated if they found a discrepancy while performing chart audits, they would have followed up with the resident/POA to determine their wishes and then make sure it is reflected in the banner and the POLST. During interview on [DATE] at 4:30 p.m., social services (SS)-A stated she pulled the code status off the EHR and checked the advanced directives documents such as POLST, to verify accuracy as well as any POA or legal guardianship paperwork when she prepared for resident’s care conferences. SS-A stated she verbalized the current code status, and asked the resident and/or POA if that is still their wishes. If resident or POA had not agreed, she would have corrected this with them. During interview on [DATE] at 10:51 a.m., trained medication aide (TMA)-C- stated she recently received education regarding resident POLST’s. TMA-C stated in the event of a medical emergency, she would look in the red binder, which is alphabetized by residents last name, to locate the necessary residents' POLST. TMA-C stated the training entailed reading the information provided, followed by a verbal quiz on the information. During interview on [DATE] at 10:55 a.m., nursing assistant (NA)-D stated he received training last night about CPR and code statuses. He stated they are to look in the red binders at the nurses’ station. NA-D stated he was told how he was to determine code status, and that the nurse was to make the call. In the event of an emergency someone checked the POLST kept at the nurses’ station in two red binders filed alphabetically. NA-D stated the DON spoke with him and signed off on his retraining. The facility policy Cardiopulmonary Resuscitation (CPR) dated [DATE], identified it was the policy of the facility to adhere to resident’s rights to formulate advance directives. Advance Directives to define the scope of medical care will be discussed with the potential resident and/or resident representatives at the time of admission. The facility will review decisions about a resident’s CPR status at each initial care conference, at quarterly care conferences, at resident and/or resident representative request as well as at the time of any permanent, significant change in the resident’s status that results in the development of a new care plan. (continued on next page)

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	08/01/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on [DATE] at 10:56 a.m., when the facility developed and implemented a systematic removal plan which was verified by interview and document review. On [DATE], the facility completed an audit of all residents' code status, reviewed the process to ensure the entered POLST information into the EMR was accurate and updated. On [DATE] licensed staff were educated regarding the updated POLST procedure and where to find a residents' code status. and continued for staff prior to their next shift. During interview on [DATE] at 11:45 a.m., director of operations (DOO) stated the facility did not have an advance directive policy. DOO stated the POLST should have been processed and entered in the EHR as any other provider order.

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	08/01/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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	08/01/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure parameter mattress (a type of mattress cover, or encasement designed to create a gentle barrier around the edge of the bed, preventing falls) was not used in a manner to restrain resident while in bed for 1 of 1 resident (R21) reviewed for restraints.Findings include: R21's annual Minimum Data Set (MDS) dated [DATE], identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. MDS did not indicate R21 utilized restraints. R21's care plan reviewed 7/31/25, identified R21 had limited physical mobility with fall risk related to weakness and limited mobility and had no recent history of falls. Care plan indicated R21 had a lipped mattress initiated on 6/21/23, to decrease the risk of falls when sitting on edge of bed and low bed to limit injuries from falls. Care plan indicated R21 was non-ambulatory and needed assistance from two staff for bed mobility and transfers. During review of R21's electronic health record (EHR), Physical Device assessment completed on 6/9/25 indicated R21 utilized grab bars that were on bed and a wheelchair. Physical device assessment did not identify the parameter mattress was assessed or utilized by R21. During observation and interview on 7/28/25 at 1:48 p.m., R21's bed had a parameter mattress in place. R21 stated she was not sure why she had the parameter mattress on the bed and she does not attempt to get out of bed by herself as she knows she is not strong enough and she waits for staff for assistance. During interview on 7/31/25 at 3:22 p.m., licensed practical nurse (LPN)-A confirmed R21 had a parameter mattress present on bed. LPN-A stated R21 was not able to get out of bed by herself and has not tried to get out of bed by herself for some time. During interview on 8/1/25 at 10:39 a.m., nursing assistant (NA)-A stated R21 had a parameter mattress in place that has been there for several years to assist R21 with not falling out of bed. NA-A stated R21 was not able to reposition herself and was not able to get out of bed by herself for approximately the past year. During interview on 8/1/25 at 10:46 a.m., NA-B stated R21 had a parameter mattress present to assist R21 with not falling out of bed. NA-B stated R21 no longer attempts to get out of her bed independently and has not for quite a while. During interview on 8/1/25 at 11:32 a.m., registered nurse clinical coordinator (RN)-A, registered nurse clinical coordinator (RN)-B and director of nursing (DON) stated R21 needed assistance to get out of bed, was a fall risk and confirmed R21 had a parameter mattress in place. Parameter mattresses were assessed through the physical device assessment and should be assessed quarterly or with a change in condition. DON stated parameter mattresses helped resident identify the edge of the bed. The mattress could be considered a restraint when it was used to prevent the resident from getting out of bed or if resident was immobile. DON confirmed R21's parameter mattress was not assessed or mentioned on the physical device assessment and should have been. RN-A, RN-B and DON stated they are not sure why R21 still had the parameter mattress in place. The facility Restraint Free Environment policy, dated 2/23/25, indicated it was the policy of the facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints. Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent tot eh resident's body that the individual cannot removed easily which restricts freedom of movement or normal access to one's body. Physical restraints may include but are not limited to placing a resident on a concave mattress so that the resident cannot independently get out of bed. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms. Physical restrains may e used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint.

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	08/01/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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	08/01/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to ensure that a safe and orderly discharge was arranged for 1 of 2 residents (R40) who was discharged against medical advice (AMA). The facility did not complete a comprehensive discharge plan, or adequate documentation of efforts to educate the resident about the risks of leaving AMA. Findings Include: R40's quarterly Minimum Data Set (MDS) dated [DATE], identified R40 had intact cognition and required minimal or limited assistance with activities of daily living (ADL)'s. R40's diagnoses included type II diabetes mellitus (DM) with other specified complication, major depressive disorder, hypertension, bilateral primary osteoarthritis of knee, postprocedural; hypothyroidism, and hyperlipidemia. R40's quarterly care conference dated 6/10/25 noted resident plan to discharge to assisted living (AL) facility once medical assistance (MA) was open. R40 would need outpatient therapy, assistance with medication management, and a commode with bars that goes over the toilet. R40's order summary report dated 6/30/25 noted discharge plan as home, alone. R40's Notice of Medicare Non-Coverage (NOMNC) listed last covered date (LCD) as 2/6/25. Review of R40's progress notes dated 7/18/25, indicated R40 left the facility with her daughter for an appointment and expressed intent to leave the facility AMA on 7/18/25. R40's daughter informed the facility of intent to return to gather resident's belongings and noted R40's refusal to enter the building. An AMA form was taken out to resident in a vehicle to sign. AMA form dated 7/18/25 at 12p, was signed by R40 as well as social worker (SS)-A was scanned into R40's EHR. No documentation of recapitulation of stay or discharge summary was noted in R40's electronic health record (EHR). R40's discharge summary and recapitulation of stay was requested 7/29/25 and provided 7/30/29. The discharge summary progress note dated 7/18/25 12:37 p.m., noted as late entry indicated the director of nursing (DON) created the entry on 7/29/25 at 8:52 p.m., and noted resident left AMA and both resident and daughter were made aware by SS-A, facility would not be responsible to arrange home services. During interview on 7/31/25 at 3:30 p.m., registered nurse (RN)-A, case manager, stated discharge planning is discussed during the care conference. During the discharge process the discharge assessment was completed in the computer, this was reviewed and signed with the resident upon completion. If the resident was going home, they also reviewed the discharge instructions. RN-A stated for a resident who voiced intent to leave the facility AMA they would get ahold of the family and resident and ensure they understood and wanted to proceed. RN-A stated they would have filed a MAARC if the discharge was unsafe. RN-A stated when discharging AMA SS-A completed the paperwork, and entered the discharge progress note which included the recapitulation of stay. RN-A stated R40 had planned to discharge to the AL facility, her daughter had called and spoke to the business office, daughter had stated she was on her way to the facility, while there she voiced financial concerns, staff from the AL came over to speak with them and explain options available, and they still decided R40 would discharge home with her daughter. RN-A stated R40 and daughter were informed facility is not responsible when discharging AMA. During interview on 7/31/25 at 3:35 p.m., DON confirmed she did go back into R40's EHR and enter a discharge summary after requested by surveyor, as it had been missed. DON stated daughter had contacted facility when they were out of facility, DON stated SS-A completed AMA form with R40 while R40 was in a vehicle. DON stated when discharging a resident, they usually gave a summary to the resident that included: medications, recent labs, and follow up appointments. DON stated R40's daughter made it very clear that they would follow up with their own provider and not to worry about it. During interview on 8/01/25 at 11:38 a.m., director of operations (DOO) stated if they were made aware of resident's intent to discharge AMA, SS-A would meet with the resident and provide education as well as inform of risks. SS-A would also encourage resident to see their primary care provider, as the facility was unable to provide additional services or arrangements for services outside of the facility such as home care. DOO stated medical provider was notified of the AMA discharge. There should have been some sort of documentation, normal things but they were not required to provide much info, and no medication information was provided for AMA discharges. Facility discharge policy requested and not received.

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	08/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered care plan for 1 of 2 residents (R25) reviewed for care planning.Findings include: R25's annual Minimum Data Set (MDS) dated [DATE], identified R25 had intact cognition and required moderate assistance with activities of daily living (ADL)'s. R25's diagnoses included acute respiratory failure with hypoxia, atrial fibrillation, hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperkalemia, depression, respiratory failure, obstructive sleep apnea, and mild cognitive impairment of uncertain or unknown etiology. R35's care plan included: (Preferred Name) has an ADL Self Care Performance Deficit r/t (related to). dated 5/16/25 and lacked goals and interventions. (Preferred Name) has (SPECIFY: Diabetes Mellitus, hyperglycemia, hypoglycemia) dated 5/16/25 and lacked goals and interventions. (Preferred Name) has altered cardiovascular status R/T (SPECIFYCARDIAC DX) (SPECIFY: With / without potential for bleeding/bruising R/T aspirin use, anticoagulant therapy, Lovenox, heparin, Plavix) dated 5/16/25 and lacked goals and interventions. (Preferred Name) has an alteration in hematological status R/T dated 5/16/25 and lacked goals and interventions. (Preferred Name) uses Antidepressant Medication due to (SPECIFY: feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping) R/T dated 5/16/25 and lacked goals and interventions. (Preferred Name) has actual/potential for (SPECIFY: Chronic, Acute, Neuropathic) Pain with need for medication management R/T (SPECIFY) dated 5/16/25 and lacked goals and interventions. (Preferred Name) is considered a vulnerable adult R/T dated 5/16/25 and lacked goals and interventions. (Preferred Name) has altered respiratory status/difficulty breathing (SPECIFY: shortness of breath) R/T (SPECIFY: Requires oxygen therapy) dated 5/16/25 and lacked goals and interventions. (Preferred Name) wishes to return to the community (SPECIFY: goals for admission and desired outcome) dated 5/16/25 and lacked goals and interventions. R25's physician orders included amlodipine and metoprolol for hypertension; Xarelto for atrial fibrillation; duloxetine for depression and anxiety; menthol-methyl salicylate cream, acetaminophen, pregabalin and tramadol for pain; and Baqsimi, Lantus and Mounjaro insulin injections for diabetes. During interview on 8/1/25 at 11:37 a.m. director of nursing (DON) and registered nurse clinical coordinators (RN)-A and RN-B stated the MDS coordinator was responsible for entering and revising resident care plans and that she left the facility in February 2025. DON confirmed R25's was not completed nor individualized. DON stated person-centered care plans are important, so staff are aware of how to care for the resident and that the care is individualized. The facility Comprehensive Care Plan policy, dated 4/25, indicated facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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	08/01/2025

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. (continued on next page)

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	08/01/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 1 of 1 resident (R21) reviewed for wheelchair usage. Further, the facility failed to ensure medications were administered per physician's order for 1 of 1 resident (R25) reviewed for assessment prior to medication administration. Findings include: R21 R21's annual Minimum Data Set (MDS) dated [DATE], identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. R21's care plan identified R21 had a self-care deficit and required assistance with transfers and locomotion in a wheelchair to reach desired destinations and utilized a wheelchair. Care plan also indicated on 7/21/25 R21 received hard back and seat custom wheelchair with foot pedals. During observation on 7/28/25 at 11:34 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor approximately four times. Staff did not provide reminders to R21 to hold her feet up. During observation and interview on 7/28/25 at 1:55 p.m., R21's foot pedals for her wheelchair were sitting in a basket that was placed on the left side of her recliner up against the wall. R21 stated staff assist her to the dining room for all meals. She had foot pedals for her wheelchair but were only used when she goes out to an appointment. R21 stated it was sometimes hard to keep her feet up when staff are pushing her down the hallway in her wheelchair. During observation on 7/30/25 at 11:41 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding and bouncing on floor. Staff did not provide reminders to R21 to hold her feet up. During observation on 7/30/25 at 12:31 p.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor approximately four times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During observation on 7/31/25 at 7:42 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. Foot pedals were attached to wheelchair but were folded up and pushed under the seat of the wheelchair. R21's feet were sliding on floor and feet bounced off the floor approximately three times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During observation on 7/31/25 at 8:24 a.m., R21 was assisted out of the dining room and was brought to the medication cart with her feet sliding on floor. During observation on 7/31/25 at 8:24 a.m., R21 was being pushed down hallway in her wheelchair with no foot pedals on. R21's feet were sliding on floor and feet bounced off the floor several times. R21 was unable to hold her feet up off ground nor did staff provide reminders to R21 to hold her feet up. During interview on 07/31/25 at 3:22 p.m., licensed practical nurse (LPN)-A stated foot pedals are used when the resident is not about to pick up their feet or needed assistant with keeping their feet off the floor. LPN-A stated foot pedals should be used for residents who are not able to keep their feet up when staff pushed the wheelchair to and from destinations. LPN-A stated R21 should use foot pedals when staff are assisting her in her wheelchair to and from destinations. LPN-A stated it was important for foot pedals to be used for safety when escorting residents in a wheelchair to and from destinations and to prevent injuries. During interview on 8/1/25 at 10:39 a.m., nursing assistant (NA)-A stated foot pedals are used as needed. NA-B stated R21 has foot pedals that should be used if staff are assisting her with propelling wheelchair. NA-A stated R21 does not use foot pedals often. During interview on 8/1/25 at 10:46 a.m., trained medication aide (TMA)-B stated foot pedals should be used for any resident who had them and needed staff assistance transporting to and from any destination. TMA-A stated R21 does have foot pedals. During interview on 8/1/25 at 11:32 a.m., director of nursing (DON) stated foot pedals are not always on the wheelchair but are stored in resident's room to be used as needed. When a resident was exhibiting signs of not being able to keep feet held off floor when being transported to and from destinations, DON expected foot pedals be placed on wheelchair and used. She expected staff to use foot pedals in all observations noted above. DON stated it was important to use foot pedals on wheelchair during transport to prevent injury and that it was best practice. A wheelchair positioning policy was requested but was not provided. R25 R25's annual MDS dated [DATE], identified R25 had intact cognition and required moderate assistance with ADL's. R25's diagnoses included acute

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	08/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess a resident for safe electric recliner usage for 1 of 1 resident (R21) reviewed for accidents.Findings include: R21's annual Minimum Data Set (MDS) dated [DATE], identified R21 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included unspecified dementia with anxiety, atrial fibrillation, anemia, hypertension, peripheral vascular disease, hyperlipidemia, arthritis, non-Alzheimer's dementia, anxiety disorder, depression, hypomagnesemia, hypokalemia, and chronic venous hypertension with ulcer of left lower extremity. R21's care plan, print date of 7/31/25, indicated staff were to encourage R21 to elevate legs in recliner. R21's care plan reviewed 7/31/25, identified R21 had limited physical mobility with fall risk related to weakness and limited mobility and had no recent history of falls. Care plan indicated R21 was non-ambulatory and needed assistance from two staff for bed mobility and transfers. During review of R21's electronic health record (EHR), Physical Device assessment completed on 6/9/25 indicated R21 utilized grab bars that were on bed and a wheelchair. Physical device assessment did not identify the electric recliner was assessed or utilized by R21. During observation and interview on 7/28/25 at 1:43 p.m., R21 was sitting in her electric recliner in her room with her legs elevated. R21 stated she was able to control the remote for the electric recliner and reached for the remote to demonstrate. R21 started to push buttons on the remote and then stopped and put the remote on the arm of the recliner. During observation on 7/28/25 at 1:55 p.m., staff rushed into R21's room as R21 had gotten her electric recliner elevated all the way up and was about to slide to the floor. Staff intervened and safely lowered the recliner without further incident. During interview on 7/28/25 at 1:58 p.m., nursing assistant (NA)-C confirmed R21 had gotten electric recliner raised up, so R21 almost slid out of the recliner onto the floor. During observation on 7/30/25 at 9:49 a.m., R21 was sitting in her electric recliner in her room with her legs elevated. Electric recliner remote was within R21's reach. During observation on 7/30/25 at 3:50 p.m., R21 was sitting in her electric recliner in her room with her feet placed on the floor. Electric recliner remote was within R21's reach. During interview on 8/1/25 at 10:39 a.m., NA-A stated R21 could not function the remote on the electric recliner and had confusion occasionally on what she is supposed to do or be doing. NA-A stated R21 sat in her recliner in the morning after breakfast with her legs elevated to help with swelling in her legs. During interview on 8/1/25 at 10:46 a.m., NA-B stated R21 does not usually attempt to get out of her recliner. NA-B stated R21 can function the remote of the electric recliner and uses the remote all the time. During interview on 8/1/25 at 11:15 a.m., trained medication aide (TMA)-A stated R21 will play/fidget with the remote of her electric recliner. During interview on 8/1/25 at 11:32 a.m., registered nurse clinical coordinator (RN)-A, registered nurse clinical coordinator (RN)-B and director of nursing (DON) stated R21 needed assistance to get out of chair, was a fall risk and confirmed R21 utilized the electric recliner in her room. Stated electric recliner should be assessed through the physical device assessment and should be assessed quarterly or with a change in condition. DON confirmed electric recliner was not assessed or mentioned on the physical device assessment and should have been. DON stated it was important for the electric recliner to be assessed to ensure the resident can use the recliner safely. An assistive device and assessment of physical devices policies were requested but was not received.

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	08/01/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a Registered Nurse (RN) was on-site for at least 8 consecutive hours on a daily basis. Lack of consistent RN coverage may result in delayed assessment, clinical decision-making, or care interventions, potentially jeopardizing resident health and safety. This failure had the potential to negatively impact resident care and oversight.Findings include: Facility payroll based journal (PBJ) staffing data report for fiscal year 2025, quarter 2 (January 1- March 31) triggered excessively low weekend staffing. Facility assessment dated [DATE]- indicated facility need for 1 RN for 40 residents. Facility staffing schedules indicated RNs were scheduled for 12-hour shifts (6am-6:30pm, and 6pm-6:30am). Review of facility staffing data submitted for PBJ report, for weekends 1/1/25-3/31/25, revealed no RN coverage for Sunday 2/23/25.During interview on 7/30/25 at 2:39 p.m., director of operations (DOO) stated the facility had a contingency plan in place for RN coverage. If the need did not meet the level to activate that plan, they would mandate overtime and activate their call tree to the director of nursing (DON) and DOO for emergency staffing needs, which included calling in qualified leadership team members, as needed (PRN) and agency staff. During interview on 7/31/25 at 8:18 a.m., staffing coordinator (SC) stated on weekends the nurse in charge would contact SC and DON if nursing staff called in. DON and SC then would look for someone to cover the open shift. DON used OnShift app (an application used to post open shifts) to post the open shift. SC stated if facility did not have a RN in the building, they would have one come in. The DON and RN case managers had an on-call rotation and were expected to come in if needed. SC stated she was trained the facility was allowed a maximum of three days per quarter with no RN coverage, but the goal was to have zero days, and to avoid using days. The facility had four PRN nurses. SC stated the facility utilized a block schedule rotation which auto populated into the monthly calendar, she then reviewed the vacation time to determine open shifts needing to be filled. The monthly schedule was published by the second week of the previous month. During interview on 7/31/25 at 1:37 p.m., human resources (HR) stated they used OnShift for scheduling and time keeping which was reviewed by the corporate HR consultant and leadership team. HR facilitated newly hired personnel, which included full-time, part-time, and PRN. HR confirmed they used a rotating two-week block schedule and strived for zero days with no RN coverage. During interview on 7/31/25 at 1:51 p.m., DOO stated when staff called in, they required a minimum of two hours prior to their scheduled shift, the charge nurse filled out a call off slip for tracking. They had contracts with agencies, and an RN on-call rotation to ensure RN coverage. DOO expected the nurse on-call to address the need accordingly. DOO stated her expectation for the on-call nurse on the weekend, was to be within one hour of the facility and able to come in if needed, at any time. During follow-up interview on 7/31/25 at 2:30 p.m., DOO explained on 2/23/25 there had been an open RN shift posted to OnShift, which had been picked up by a licensed practical nurse (LPN). DOO believed SC had accepted, and this had not been recognized as an error.

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	08/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices during meal service for 3 of 3 dining observations. Specifically, staff failed to intervene when a resident (R25) was observed touching the tops of other residents' coffee cups during meal service, creating a risk for cross-contamination and transmission of communicable diseases.Findings include: During observation on 7/28/25 at 11:38 a.m., during a lunch observation in the main dining room, R25 was observed walking around the dining room and stopping at multiple tables. R25 was observed touching the tops/rims of coffee cups, that were placed on the seat of his walker, when handing them out to other residents. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During observation on 7/30/25 at 11:39 a.m., during a lunch observation in the main dining room, R25 was observed walking around the dining room and stopping at multiple tables to pick up coffee cups. R25 was observed touching the tops/rims of coffee cups when handing them out to other residents. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During observation on 7/31/25 at 8:06 a.m., during a breakfast observation in the main dining room, R25 was observed walking to a co-resident and asking if she would like more coffee. Co-resident was holding onto handle of coffee cup and handed it to R25 who gripped the coffee cup around the top/rim of coffee cup. Staff present in the dining area did not redirect or intervene to prevent R25 from touching the drinkware of other residents. During interview on 8/1/25 at 10:53 a.m., nursing assistant (NA)-B stated R25 liked to get coffee for other residents in the dining room and did so at every meal. During interview on 7/31/25 at 3:37 p.m., Infection Preventionist (IP) acknowledged that residents should not be touching the food or drink items of others, and staff should intervene to prevent such contact to avoid possible transmission of infectious agents. The IP further stated that this behavior was not in accordance with the facility's infection control protocols. A copy of the facility's Infection Prevention and Control policy related to dining services was requested on 8/1/25 but was not received by the time of the survey.