DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 27LG
Facility ID: 00705

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245102**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAUER HEALTH CARE**
(L4) **1635 WEST SERVICE DRIVE**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: 7 (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/24/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **71** (L18)

13.Total Certified Beds **71** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	71			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 03/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/19/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
00

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/07/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5102

On 02/24/2015, a Post Certification Revisit (PCR) was completed by the Department of Health and on 01/05/2015, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 11/25/2014 standard survey. Refer to the CMS 2567b for both health and life safety code.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245102

April 3, 2015

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

Dear Ms. Blair:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 19, 2015 the above facility is certified for:

71 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 71 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.
If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Certified Mail #7010 1670 0000 8044 4400

March 9, 2015

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

Re: Project # S5102024

Dear Ms. Blair:

On January 22, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 25, 2014 with orders received by you on December 15, 2014.

State licensing orders issued pursuant to the last survey completed on November 25, 2014 and found corrected at the time of this January 22, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on November 25, 2014, found not corrected at the time of this January 22, 2015 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use	**$ 300.00**
20910 -- MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence	**$ 350.00**
21390 -- MN Rule 4658.0800 Subp. 4 A-I -- Infection Control	**$ 300.00**
21805 -- MN St. Statute 144.651 Subd. 5 -- Patients & Residents Of Hc Fac.Bill Of Rights	**$ 250.00**

The details of the violations noted at the time of this revisit completed on January 22, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

On February 24, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program, completed a second reinspection of your facility to determine correction of **MN Rule 4658.0400, Subp. 1 & 2, MN Rule 4658.0400, Subp. 3 A-C, MN Rule 4658.0525, Subp. 3**. At the time of the February 24, 2015 revisit, MN Rule 4658.0400, Subp. 1 & 2, MN Rule 4658.0400, Subp. 3 A-C and MN Rule 4658.0525, Subp. 3 were found to be in compliance. State licensing orders found not corrected at the time of the January 22, 2015 revisit and subject to penalty assessment, that were found corrected at the time of the February 24, 2015 revisit, are listed on the attached Revisit Report Form.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1200.00.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

If you choose to not request a hearing, you are required to submit a check, made payable to the Commissioner of Finance, Treasury Department, State of Minnesota, in the amount of $1200.00 within 15 days of the receipt of this notice. That check should be forwarded to the Minnesota Department of Health, Division of Compliance Monitoring, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gary Nederhoff, Rochester District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245102	A. Building B. Wing	2/24/2015

Name of Facility	Street Address, City, State, Zip Code
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**02/19/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**02/19/2015**	ID Prefix **F0310** Reg. # **483.25(a)(1)** LSC	**02/19/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	**02/19/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**02/19/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/23/2015	15425	02/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/25/2014	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

March 17, 2015

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

Re: Reinspection Results - Project Number S5102024

Dear Ms. Blair:

On February 24, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 24, 2015 with orders received by you on January 29, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

AH Form Approved
4/13/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00705	A. Building B. Wing	2/24/2015

Name of Facility	Street Address, City, State, Zip Code
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	02/19/2015	ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. LSC	02/19/2015	ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. LSC	02/19/2015
ID Prefix 21805 Reg. # MN St. Statute 144.651 Sul LSC	02/19/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 27LG
Facility ID: 00705

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245102**

2. STATE VENDOR OR MEDICAID NO. (L2) **493543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAUER HEALTH CARE**
(L4) **1635 WEST SERVICE DRIVE**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/22/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **71** (L18)

13.Total Certified Beds **71** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	71			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 02/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/24/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/19/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/07/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5102

Based on the deficiencies cited by this Department during the standard survey completed November 25, 2014 and lack of verification of compliance with the health deficiencies at the time of the January 29, 2015 notice. The standard survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

We recommended the following remedy to the CMS Region V office. CMS concurred with our recommendation which are as follows:

-Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 25, 2015. (42 CFR 488.417 (b))

-The facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 25, 2015.

On January 22, 2015, the Minnesota Department of Health completed a revisit to verify compliance. The following deficiencies were not corrected:

-F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality
-F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
-F0310 -- S/S: E -- 483.25(a)(1) -- Adls Do Not Decline Unless Unavoidable
-F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
-F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens

As a result of none compliance, the Department is imposing the following category 1 remedy: -State Monitoring effective February 15, 2015. (42 CFR 488.422)

Post certification visit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 29, 2015

Ms Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

RE: Project Number S5102024

Dear Ms. Blair:

On December 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 25, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 22, 2015, the Minnesota Department of Health and on January 5, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on November 25, 2014.

However, compliance with the health deficiencies issued pursuant to the November 25, 2014 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 25, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 25, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 25, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Sauer Health Care is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 25, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own

expense.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 10, 2015

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

RE: Project Number S5102024

Dear Ms. Blair:

On January 29, 2015, the Department recommended the following remedy to the CMS Region V office, CMS concurred with our recommendation and authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 25, 2015. (42 CFR 488.417 (b))

In addition, this Department notified you in our letter of January 29, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 25, 2015.

This was based on the deficiencies cited by this Department during the standard survey completed November 25, 2014 and lack of verification of compliance with the health deficiencies at the time of our January 29, 2015 notice. The standard survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On January 22, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 25, 2014. The deficiencies not corrected are as follows:

F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality
F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

F0310 -- S/S: E -- 483.25(a)(1) -- Adls Do Not Decline Unless Unavoidable
F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective February 15, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 25, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 25, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 25, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Sauer Health Care is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective February 25, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter.

Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245102	A. Building B. Wing	1/22/2015

Name of Facility	Street Address, City, State, Zip Code
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	01/04/2015	ID Prefix F0242 Reg. # 483.15(b) LSC	01/04/2015	ID Prefix F0272 Reg. # 483.20(b)(1) LSC	01/04/2015
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	01/04/2015	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	01/04/2015	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	01/04/2015
ID Prefix F0371 Reg. # 483.35(i) LSC	01/04/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	02/12/2015	31221	01/22/2015
CMS RO				

Followup to Survey Completed on: 11/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on January 21 & 22, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there were tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 241} SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining service for 4 of 20 residents (R46, R62, R55, and R58) observed during the dining experience. Findings include:	{F 241}	In response to the above stated citation Sauer Health Care has taken the following action: " A coaching and re-education was completed on 2/17/2015 with staff member observed by state surveyor in the dining area where the following issues	2/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/19/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 241}

Continued From page 1

R46, R62, R55, R58 who were dependent on staff for eating assistance were not provided timely and consistent assistance to ensure a dignified dining experience for each resident was provided.

Nursing assistant (NA)-A was observed sitting at table with R46, R62, R55, and R58. At 11:44 a.m. NA-A was observed to leave the table R46 attempted to feed self while the other residents remained seated with no attempt to feed self although their food was sitting in front of them. At 11:47 NA-A returned to sit between R62 and R55 and set up drinks for them, then NA-A got up and walked around the table to sit between R58 and R46 to assist them to eat. At 12:03 p.m. R55 and R62 remained sitting at the table not eating or being encouraged by staff to eat the meal. NA-A assisted R46 to place food on the fork. At 12:08 p.m. R55 was observed not to eat and was not being encouraged or assisted to eat. At 12:12 p.m. R62 was sleeping at the table and had not been encouraged to eat. At 12:14 p.m. NA-A was observed to move between R58 and R55 to assist them to eat as they had not been helped or cued to eat for the past 24 minutes. NA-A had not warmed the meal for R58 and R55 before starting to assist them to eat the food.

NA-A was interviewed at 12:00 p.m. on 1/22/15. NA-A stated only one person was assigned to help at the restorative nursing table which included R58, R46, R62, and R55. NA-A said that R62 would never feed herself and that R58 had advanced dementia and at times also needed help. NA-A stated R55 and R46 were able to feed self but needed encouragement to do so. During an interview on 1/22/15 at 4:30 p.m.

{F 241}

were noted: getting up and leaving the table with residents present and not having other assistance present, not offering cuing or encouragement as needed to residents, not attempting to wake sleeping residents for dining and not attempting to warm food that had been observed to be at the table for 24 minutes before attempting to assist resident to eat food.

" Following the exit of the state survey team a message was sent to the DON and the dietary manager from the administrator on 2/2/2015 directing the following changes to be made immediately in the dining room while further discussion and planning was ongoing to make improvements:

o Following service of the meal a dietary staff member will remain in the dining room throughout the meal and will stop at tables to question if anything is needed by residents or nursing staff members to eliminate the need for nursing staff to get up and interrupt the dining assistance being provided.

" On 2/5/2015 a message was sent from the administrator to the management team indicating that Pathway Health had been contacted and arrangements have been made for a consultant to visit the facility on 2/18/2015 and 2/19/2015 to observe the dining process and then make recommendations on how to improve the process to ensure a dignified experience for all residents. These will be implemented as appropriate following her exit report findings.

" R46 care plan and directives for

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	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 241} Continued From page 2

the director of nursing (DON) stated that usually only one staff member was assigned to assist residents at the restorative table which should have only residents that need a restorative dining program. DON stated she did not know why other staff did not assist when residents needed help.

R46 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R46 was observed from 11:10 a.m. to 12:00 p.m. to be sleeping in the wheelchair while a plate of food was in front of her at the table. No staff was sitting beside her to assist her with eating or to cue her to eat. R46 was observed to keep pushing the wheelchair away from the table and the nurse or nursing assistant would push her back to the table. At one time NA-A stood for a few minutes to encourage her to eat and assisted her with cutting the food.

R46's care plan printed 1/22/15 identified self-care deficit and indicated R46 was able to feed herself, but perhaps needed some assistance.

During an interview at 4:30 p.m. on 1/22/15 the director of nursing (DON) stated R46 was to be cued for eating.

R62 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R62 was observed during the lunch meal on 1/22/15 from 11:05 a.m. to 12:00 p.m. R62 made no attempt to eat independently. For a short time NA-A assisted the resident to eat and then left R62 to help another resident then came back and was observed to cut R62 food.

{F 241}

dining were modified on 2/14/2015.
" R62 care plan and directives for dining were modified on 2/14/2015. Additional modifications were made on 2/19/2015.
" R55 care plan and directives for dining were modified on 2/14/2015.
" R58 care plan and directives for dining were modified on 2/14/2015.
" A survey that was created by the dietary manager will be completed with all residents who are able to be interviewed by 3/31/2015 to evaluate their satisfaction with their dining experience and to offer suggestions on how to improve their overall experience.
" This survey was last completed February, 2014.
" Specific designation of restorative dining table has been eliminated with the following message being delivered to staff on 2/20/2015:
o There will no longer be a designated table for restorative dining. Several of our residents have dining orders that can be considered restorative such as cuing to eat, staff placing food on a utensil and then having the resident place food in mouth themselves and placing a beverage in the residents hand and having them drink it independently. All of these tasks can be considered a restorative form of dining and ANY staff member can provide this service as all are trained in dining assistance. The restorative staff members will be in the dining area for all meals as in the past but will not be solely responsible for designated residents. All staff is expected

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{F 241}	Continued From page 3 R62's care plan printed 1/22/15 indicated R62 was to be provided meals at the restorative dining table and that staff were to encourage the resident to eat. During an interview at 4:30 p.m. 1/22/15 the director of nursing (DON) stated R62 was to be totally assisted to eat. R55 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R55 was observed at lunch on 1/22/15 from 11:25 am to 12:00 p.m. and made no attempt to eat independently or with cueing and NA-A assisted her intermittently while going back and forth between two residents. R55 ' s care plan printed 1/22/15 indicated R55 was on the restorative nursing program for eating/swallowing. Staff was to provide cueing to promote independent eating and assistance as needed for task completion. In another area of the care plan identified a problem of self-care deficit and indicated R55 needed extensive assistance for eating During an interview at 4:30 p.m. 1/22/15 the director of nursing stated R55 was to be cued for eating. R58 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R58 was observed during the noon meal on 1/22/15 between 11:35 a.m. and 12:00 p.m. and received intermittent assistance to eat by NA-A who was helping several residents during the meal service. R58's care plan printed 1/22/15 indicated	{F 241}	to offer assistance to any resident who needs it based on their care plan directives. " The following message is being is delivered to staff on 2/20/2015: o Anytime a change in a residents ability to complete dining tasks as indicated is noted staff is to immediately notify a licensed staff member so the current care plan and dining room seating can be evaluated for needed changes, modifications and updates. " An audit of the dining experience will be completed randomly to ensure a dignified dining experience. " All staff will be educated on this plan via electronic mailing, paper copy in communication binder in the break room and/or through their department communication methods by 2/20/2015 with a live in-service planned for nursing and dietary staff members on 3/5/2015. All nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating knowledge of plan as stated above by this same date. Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as certified nursing assistants and dietary staff members with overall compliance being the responsibility of the Director of Nursing Services and the Dietary Director.	

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{F 241}	Continued From page 4 self-care deficit and that R58 needed limited assistance with eating. During an interview on 1/22/15 at 4:30 p.m. the director of nursing indicated R58 was to be totally assisted to eat. DON stated R58 sat at the restorative table and had a restorative dining program. Also DON said that staff was to set-up the meal for R58, provide verbal cues, and provided hand over hand assistance as needed.	{F 241}		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow each resident's care plan which was developed based on the comprehensive assessment for 4 of 20 residents (R46, R62, R55, R58) needing staff assistance with eating; the facility failed to follow a hospice care plan for 1 of 1 resident (R14) who had a change in health status and physician had not been contacted timely; lastly the facility failed to follow 1 of 3 residents (R54) care plan addressing personal hygiene needs. Findings include: Lack of providing eating assistance as directed in the care plan:	{F 282}	In response to the above stated citation Sauer Health Care has taken the following action: " A coaching and re-education was completed on 2/17/2015 with staff member observed by state surveyor in the dining area where the following issues were noted: getting up and leaving the table with residents present and not having other assistance present, not offering cuing or encouragement as needed to residents, not attempting to wake sleeping residents for dining and not attempting to warm food that had been observed to be at the table for 24 minutes before attempting to assist resident to eat food.	2/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ____ B. WING ____	R 01/22/2015

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{F 282}

Continued From page 5

R46, R62, R55, R58 observed on 1/22/15 from 11:05 a.m. to 12:00 p.m. seated at a table designated for residents who needed staff assistance to eat their meals.

R46 was observed from 11:10 a.m. to 12:00 p.m. and was observed to be sleeping in the wheelchair while R46's food sat in front of her uncovered. No staff was sitting beside her to assist her with eating or to cue her to eat. R46 was observed to keep pushing the wheelchair away from the table and the nurse or nursing assistant would push her back to the table. One staff stood to encourage her to eat and assisted her with cutting the food. R36 ate less than 25% of the meal.

The care plan printed 1/22/15 identified self-care deficit. The care plan indicated R46 was able to feed herself, but perhaps needed some assistance to open things, but most items in the dining room were ready to eat. The care plan also indicated staff was to be there to help R46 eat.

During an interview at 4:30 p.m. on 1/22/15 the director of nursing (DON) stated R46 was to be cued for eating. The DON stated R46 was able to take a fork to her mouth, but did not always have food on the fork. DON stated NA-A should encourage R46 to eat and that it would be okay to talk to R46 across the table

R62 was observed during the lunch meal on 1/22/15 from 11:05 a.m. to 12:00 p.m. R62 made no attempt to feed self. NA-A assisted the resident to eat. NA-A was not observed to provide guidance for eating safely or encouraged to eat or drink. At one point NA-A left R62 and

{F 282}

" Following the exit of the state survey team a message was sent to the DON and the dietary manager from the administrator on 2/2/2015 directing the following changes to be made immediately in the dining room while further discussion and planning was ongoing to make improvements:
o Following service of the meal a dietary staff member will remain in the dining room throughout the meal and will stop at tables to question if anything is needed by residents or nursing staff members to eliminate the need for nursing staff to get up and interrupt the dining assistance being provided.
" On 2/5/2015 a message was sent from the administrator to the management team indicating that Pathway Health had been contacted and arrangements have been made for a consultant to visit the facility on 2/18/2015 and 2/19/2015 to observe the dining process and then make recommendations on how to improve the process to ensure a dignified experience for all residents. These will be implemented as appropriate following her exit report findings.
" R46 care plan and directives for dining were modified on 2/14/2015.
" R62 care plan and directives for dining were modified on 2/14/2015. Additional modifications were made on 2/19/2015.
" R55 care plan and directives for dining were modified on 2/14/2015.
" R58 care plan and directives for dining were modified on 2/14/2015.
" A survey that was created by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 282}

Continued From page 6

moved over to cut R62 food.

The care plan printed 1/22/15 indicated R62 was at a potential for nutritional risk and was to be provided meals at the restorative dining table. The care plan directed staff were to encourage resident to drink, to tuck chin, to sit at 90 degrees, to encourage through clearing and double swallow. In another area of the care plan the interventions noted R62 was totally dependent on staff to eat.

During an interview at 4:30 p.m. 1/22/15 the director of nursing (DON) stated R62 was to be totally assisted to eat. The DON stated R62 should not be seated at the restorative table if she is unable to eat independently.

R55 was observed at lunch on 1/22/15 from 11:25 am to 12:00 noon. R55 was being fed by NA-A and made no attempt to feed herself.

The care plan printed 1/22/15 indicated R55 was on the restorative nursing program for eating/swallowing. Staff was to provide cueing to promote independent eating and assistance as needed for task completion. In another area of the care plan identified a problem of self-care deficit and indicated R55 needed extensive assistance for eating and help with the actual eating process. The care plan also directed R55 needed encouragement to eat and needed to be fed.

During an interview at 4:30 p.m. 1/22/15 the director of nursing stated R55 was to be cued for eating.

R58 was observed during the noon meal on

{F 282}

dietary manager will be completed with all residents who are able to be interviewed by 3/31/2015 to evaluate their satisfaction with their dining experience and to offer suggestions on how to improve their overall experience.

" This survey was last completed February, 2014.

" Specific designation of restorative dining table has been eliminated with the following message being delivered to staff on 2/20/2015:

o There will no longer be a designated table for restorative dining. Several of our residents have dining orders that can be considered restorative such as cuing to eat, staff placing food on a utensil and then having the resident place food in mouth themselves and placing a beverage in the residents hand and having them drink it independently. All of these tasks can be considered a restorative form of dining and ANY staff member can provide this service as all are trained in dining assistance. The restorative staff members will be in the dining area for all meals as in the past but will not be solely responsible for designated residents. All staff is expected to offer assistance to any resident who needs it based on their care plan directives.

" The following message being is delivered to staff on 2/20/2015:

o Anytime a change in a residents ability to complete dining tasks as indicated is noted staff is to immediately notify a licensed staff member so the current care plan and dining room seating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 282}

Continued From page 7

1/22/15 between 11:35 a.m. and 12:00 N. R58 was being fed by NA-A.

The care plan printed 1/22/15 indicated self-care deficit and that R58 needed limited assistance with eating. The care plan interventions indicated R58 needed assistant with set up and cueing and at times needed to be actually fed.

NA-A was interviewed at 12:00 noon on 1/22/15. NA-A stated only one person was assigned to help at the restorative nursing table. She added R62 would never feed herself and that R58 had advanced dementia and at times also needed help. NA-A stated R55 and R46 were able to feed self but needed encouragement to do so. During an interview on 1/22/15 at 4:30 p.m. the director of nursing (DON) stated that usually only one staff member was assigned to assist at the restorative table which should have only residents that need a restorative dining program. DON stated she did not know why other staff did not assist

During an interview on 1/22/15 at 4:30 p.m. the director of nursing indicated R58 was to be totally fed. DON stated R58 sat at the restorative table and had a restorative dining program. Staff was to set-up the meal for R58, provides verbal cues, and provided hand over hand assistance as needed. DON stated R58 should have finger foods. DON stated the care plan identified what the facility hoped would be provided and now needed to be updated.

Lack of timely notification of change in condition:

R14's interdisciplinary team (IDT) progress notes dated 1/19/15 at 6:17 p.m. said R14 experienced

{F 282}

can be evaluated for needed changes, modifications and updates.

" Coaching and education was provided on 2/17/2015 to the staff member identified as working on 1/19/2015 when the failure to complete proper notification was indicated.

" The policy Change of Condition, Physician Notification dated 11/11/2014 was modified on 2/14/2015 with change of title as follows: Change of Condition, Provider Notification and directives of the need to notify Hospice services was added.

" The job description for Trained Medical Assistant was reviewed and found to be current and appropriate with directive being present on the need to consult with a licensed staff member before providing any as needed PRN medications.

" The following message is being is delivered to staff on 2/20/2015:

o Any changes in resident condition or status that is considered to be significant or not normal per baseline status must be communicated to a provider and when applicable to Hospice Service Agency.

o TMA staff MUST consult with a licensed staff member prior to administration of ANY as needed, PRN medications.

o A licensed staff member MUST make an evaluation/assessment note in the permanent record to indicate the indication for ANY as needed, PRN medications that are administered by a TMA based on that nurse s directive.

" Shaving was provided to R54

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 282}	Continued From page 8 shortness of breath, sweating, and complained of chest pain and stated, "Help me." The medication administration record (MAR) noted R14 was administered as needed Lorazepam (anti-anxiety medication), three times between 6:40 p.m. and 7:50 p.m. on 1/19/15; as needed Duoneb (respiratory medication) one time; and as needed morphine (narcotic pain medication) twice between 6:10 p.m. and 9:30 p.m. Further review of the MAR indicated R14 had not received as needed morphine, Lorazepam or Duoneb at any other time from January 1, 2015 to January 22, 2015. The IDT progress note dated 1/19/15 at 6:17 p.m. and it read a nurse had assessed lung and heart sounds, but had not notified the physician, nurse practitioner or hospice nurse with the deterioration of health status. Review of the interdisciplinary progress notes of 1/19/15 through 1/21/15 did not document notification of physician (MD), nurse practitioner (NP), or hospice nurse. R14's care plan printed 1/22/15 noted a history of myocardial infarction and a history of coronary artery disease (CAD). The interventions directed staff to monitor/document/report to nursing, nurse practitioner or medical doctor of any signs or symptoms of CAD, chest pain or pressure, shortness of breath, or excessive sweating. A hospice form directed that with a change in condition, hospice staff were to be immediately notified. The director of nursing (DON) was interviewed on 1/22/15 at 10:15 a.m. and stated she was unaware of this incident and would check with the LPN who was working that evening. At 12:52 p.m. DON stated the nurse should have completed an assessment prior to the medications and for a trained medication aide (TMA) to give the as needed medications. The	{F 282}	immediately on 1/21/2015 following report of finding of hairs present on neck and upper lip. " R54 care plan for personal hygiene/oral care was modified on 2/14/2015. " An alert was set up on 2/16/2015 in the PCC system to indicate to the licensed staff when the task of shaving is documented as not being done for 48 hours or more. " The following message was sent out to staff on 2/16/2015: o As a part of our plan of correction following the recent revisit from the state, shaving has been added to EVERY resident as a daily task that needs to be signed off on. An alert has been set up to trigger to the dashboard if the CNA indicates anything other than yes as an answer to this task. " Audit that was established following the initial survey will have frequency increased and will be ongoing. " An audit of the dining experience will be completed randomly to ensure a dignified dining experience. " All nursing staff has been assigned the EduCare training module Personal Cares. This module includes shaving. Staff is required to complete a skills demonstration assessment and all will have this completed 4/7/2015. " All staff will be educated on this plan via electronic mailing, paper copy in communication binder in the break room and/or through their department communication methods by 2/20/2015 with a live in-service planned for nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 282}	Continued From page 9 DON verified the documentation did not indicate that an assessment was completed before the medications were given. On 1/22/15 at 2:40 p.m. DON stated she did not know if the registered nurse on duty that evening had been notified and verified the documentation did not indicate the physician, nurse practitioner or hospice had been notified as directed in the plan of care. The facility policy Change of Condition, Physician Notification dated 11/11/14 was reviewed. The policy read, "The attending physician or physician/NP on call will be notified with changes in a resident's condition or health status ..." The policy also identified symptoms of shortness of breath and chest pain as changes in condition that were to be reported. The policy procedure also directed the charge nurse or supervisor was to be notified. Lack of providing nail care as directed on the care plan: R54 was observed on 1/21/15 at 1:05 p.m. with long white facial hair on the left side of her neck and facial hair on her upper lip. The quarterly Minimum Data Set dated 12/9/14 indicated R54 had a brief interview for mental status score of 6 which indicated severe cognitive impairment, required limited assistance of one staff with personal hygiene. The care plan dated 9/22/13 indicated R54 had, an "ADL [activity of daily living] Self Care Performance Deficit r/t [related to] her dementia. She needs supervision only with her ADLs." Interventions included, "R54 is able to do her own personal cares, but again needs to be supervised." The nursing assistant flow sheet indicated R54 required supervision with activities of daily living and directed staff to assist with hair care/grooming.	{F 282}	and dietary staff members on 3/5/2015. All nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating knowledge of plan as stated above by this same date. Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 282}	Continued From page 10 R54's facial hair on her neck and upper lip was verified during an observation by the director of nursing (DON) on 1/21/15 at 2:02 p.m. On 1/21/15 at 2:06 p.m. the DON verified R54's care plan read, "Is able to do her own personal cares, but again needs to be supervised" and stated this would include facial hair removal. The DON verified the facility did not follow the care plan for personal hygiene for R54.	{F 282}		
{F 310} SS=E	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide dining services to assist the resident to maintain or gain abilities for 4 of 4 residents (R46, R62, R55 and R58) reviewed during dining and failed to ensure 1 of 3 residents (R54) had facial hair removed. Findings include: R46, R62, R55 and R58 were observed on 1/22/15 from 11:05 a.m. to 12:00 p.m. R46, R62,	{F 310}	In response to the above stated citation Sauer Health Care has taken the following action: " A coaching and re-education was completed on 2/17/2015 with staff member observed by state surveyor in the dining area where the following issues were noted: getting up and leaving the table with residents present and not having other assistance present, not offering cuing or encouragement as	2/19/15

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	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 310} Continued From page 11

R55 and R58 sat at a table designated by the facility as the restorative table which means the residents needed various amounts of assistance to eat.

R46 was observed from 11:10 a.m. to 12:00 p.m. R46 was observed to be sleeping in the wheelchair while the food was in front of her at the table. No staff was sitting beside her to assist her with eating or to cue her to eat. R46 was observed to keep pushing the wheelchair away from the table and the nurse or nursing assistant would push her back to the table. One nurse stood for a few moments to encourage her to eat and assisted her with cutting the food and then left

R46 ' s care plan printed 1/22/15 identified self-care deficit. The care plan indicated R46 was able to eat independently however, needed some assistance to open things, but most items in the dining room were ready to eat. The care plan also indicated staff was to be there to help R46 eat.

During an interview on 1/22/15 at 12:00 p.m. nursing assistant (NA)-A stated R46 was able to feed self but needed encouragement to do so. During an interview at 4:30 p.m. on 1/22/15 the director of nursing (DON) stated R46 was to be cued for eating. The DON stated R46 was able to take a fork to her mouth, but did not always have food on the fork. DON stated NA-A should encourage R46 to eat.

R62 was observed during the lunch meal on 1/22/15 from 11:05 a.m. to 12:00 p.m. R62 made no attempt to eat independently. NA-A occasionally assisted the resident to eat and

{F 310}

needed to residents, not attempting to wake sleeping residents for dining and not attempting to warm food that had been observed to be at the table for 24 minutes before attempting to assist resident to eat food.

" Following the exit of the state survey team a message was sent to the DON and the dietary manager from the administrator on 2/2/2015 directing the following changes to be made immediately in the dining room while further discussion and planning was ongoing to make improvements:

o Following service of the meal a dietary staff member will remain in the dining room throughout the meal and will stop at tables to question if anything is needed by residents or nursing staff members to eliminate the need for nursing staff to get up and interrupt the dining assistance being provided.

" On 2/5/2015 a message was sent from the administrator to the management team indicating that Pathway Health had been contacted and arrangements have been made for a consultant to visit the facility on 2/18/2015 and 2/19/2015 to observe the dining process and then make recommendations on how to improve the process to ensure a dignified experience for all residents. These will be implemented as appropriate following her exit report findings.

" R46 care plan and directives for dining were modified on 2/14/2015.

" R62 care plan and directives for dining were modified on 2/14/2015. Additional modifications were made on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 310}	Continued From page 12 between physically helping R62 eat food NA-A assisted another resident and did not encourage R62 to eat. R62 ' s care plan printed 1/22/15 indicated R62 had the potential for nutritional risk and was to be provided meals at the restorative dining table. The care plan directed staff were to encourage resident to drink, to tuck chin to promote safe swallowing, to sit at 90 degrees, to encourage through clearing and double swallow. The quarterly Minimum Data Set dated 11/18/14 indicated R62 required extensive assist of one to eat. During an interview on 1/22/15 at 12:00 p.m. NA-A stated R62 never eaten independently and needed full assistance to eat. During an interview at 4:30 p.m. 1/22/15 the director of nursing (DON) stated R62 was to be totally assisted to eat. R55 was observed at lunch on 1/22/15 from 11:25 am to 12:00 p.m. R55 was being assisted to eat by NA-A and R55 made no attempt to eat independently. R55 ' s care plan printed 1/22/15 indicated R55 was on the restorative nursing program for eating/swallowing. Staff was to provide cueing to promote independent eating and assistance as needed for task completion. During an interview on 1/22/15 at 12:00 p.m. NA-A stated R55 was able to eat independently but needed encouragement to do so. During an interview at 4:30 p.m. on 1/22/15 the director of nursing stated R55 was to be cued for eating.	{F 310}	2/19/2015. " R55 care plan and directives for dining were modified on 2/14/2015. " R58 care plan and directives for dining were modified on 2/14/2015. " Shaving was provided to R54 immediately on 1/21/2015 following report of finding of hairs present on neck and upper lip. " R54 care plan for personal hygiene/oral care was modified on 2/14/2015. " An alert was set up on 2/16/2015 in the PCC system to indicate to the licensed staff when the task of shaving is documented as not being done for 48 hours or more. " The following message was sent out to staff on 2/16/2015: o As a part of our plan of correction following the recent revisit from the state, shaving has been added to EVERY resident as a daily task that needs to be signed off on. An alert has been set up to trigger to the dashboard if the CNA indicates anything other than yes as an answer to this task. " Audit that was established following the initial survey will have frequency increased and will be ongoing. " An audit of the dining experience will be completed randomly to ensure a dignified dining experience. " All nursing staff has been assigned the EduCare training module Personal Cares. This module includes shaving. Staff is required to complete a skills demonstration assessment and all will have this completed 4/7/2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 310}

Continued From page 13

R58 was observed on 1/22/15 between 11:35 a.m. and 12:00 p.m. R58 was being assisted to eat by NA-A.

R58 ' s care plan printed 1/22/15 indicated self-care deficit and that R58 needed limited assistance with eating. The care plan interventions indicated R58 needed assistant with set up and cueing and at times needed to be actually fed.

During an interview on 1/22/15 at 4:30 p.m. the director of nursing said R58 need full assistance to eat.
R54 was observed on 1/21/15 at 1:05 p.m. with long white facial hair on the left side of her neck and facial hair on her upper lip.

The quarterly Minimum Data Set dated 12/9/14 indicated R54 had a brief interview for mental status score of 6 which indicated severe cognitive impairment, required limited assistance of one staff with personal hygiene. The care plan dated 9/22/13 indicated R54 had, an "ADL [activity of daily living] Self Care Performance Deficit r/t [related to] her dementia. She needs supervision only with her ADLs." Interventions included, "R54 is able to do her own personal cares, but again needs to be supervised." The nursing assistant flow sheet indicated R54 required supervision with activities of daily living and directed staff to assist with hair care/grooming.

R54's facial hair on her neck and upper lip was verified during an observation by the director of nursing (DON) on 1/21/15 at 2:02 p.m.

On 1/21/15 at 2:06 p.m. the DON stated facial hair audits were completed on a random basis

{F 310}

" All staff will be educated on this plan via electronic mailing, paper copy in communication binder in the break room and/or through their department communication methods by 2/20/2015 with a live in-service planned for nursing and dietary staff members on 3/5/2015. All nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating knowledge of plan as stated above by this same date.

Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 310}	Continued From page 14 and R54 had not been looked as a part of the audits process. The DON verified R54's care plan read, "Is able to do her own personal cares, but again needs to be supervised" and stated this would include facial hair removal. The DON verified R54's care plan did not indicate R54 refused or declined assistance with facial hair removal and verified the facility did not follow the plan of care for personal hygiene for R54. On 1/22/15 at 11:25 a.m. the DON stated residents were to have assistance with facial hair removal on their bath days and as needed. The DON stated part of the facility education for their plan of correction to staff was they should be looking for facial hair as a part of the morning cares and completing shaving cares as needed. The DON verified based on her observation of R54's facial hair on 1/21/15 she would have expected R54 to have had her facial hair removed during morning cares yesterday. The DON verified the facility failed to follow their policy to remove facial hair as needed. Facial Hair Removal/Hygiene policy dated 1/16-13 read,"...Female residents' facial hair should be shaved as indicated weekly during her tub/shower bath and as requested or needed between weekly baths ...Document that shaving has been completed. If a resident refuses shaving, this will be documented as a refusal."	{F 310}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	{F 315}		2/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 15 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility had not completed a comprehensive reassessment for urinary tract infection (UTI) for 1 of 3 residents (R20) reviewed for recurrent UTIs Findings include: R20 had a history of recurrent UTIs but lacked a comprehensive reassessment to determine risk factors (what about lack of interventions developed for UTIs) for development of urinary tract infections and based on these assessments interventions were developed to reduce or illuminate the chance of having a UTI. A comprehensive nursing assessment dated 12/15/14 identified palliative care, dysphagia, and anxiety as diagnoses for R20. The quarter Minimum Data Set (MDS) dated 12/18/14 identified R20 as having frequent incontinence, needing extensive assistance with toilet use and personal hygiene. The MDS did not identify the resident had an indwelling catheter or a history of having UTIs. The director of nursing (DON) provided a copy of R20's comprehensive nursing assessment dated	{F 315}	In response to the above stated citation Sauer Health Care has taken the following action: " An assessment titled Urinary Tract Infection Risk Assessment was created on 2/17/2015. This assessment will be completed on all residents identified as having frequent or recurrent UTIs as identified by having more than 2 in 6 months or 3 in 1 year. These will be completed by 3/31/2015. " All other residents will have this assessment completed at admission, and/or with quarterly assessment schedule. " An audit will be completed to ensure these are being done per the planned schedule. " R20 had a Urinary Tract Infection Risk Assessment completed on 2/17/2015. " Policy titled Urinary Tract Infection (UTI) Identification, Treatment, Prevention and Management that was revised following the initial state survey was reviewed and revised again on 2/17/2015 to include directives to assess for risk and develop interventions based on findings. " All staff will be educated on this plan via electronic mailing, paper copy in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 16 12/15/14. This was reviewed with the DON on 1/22/15 at 3:30 p.m. The form only had questions that were checked yes or no. However, there was not question/s related to having UTIs. There was no analysis of the forms questions marked yes to determine a comprehensive reassessment had been completed. The director of nursing was asked for any other information related to a comprehensive bladder assessment and none was provided. Review of the undated policy procedure Urinary Tract Infection (UTI) Prevention and Management. However, it did not direct staff to assess resident's risk for UTIs and develop intervention. During an interview on 1/21/15 at 2:45 p.m. the director of nursing she indicated all residents at risk to develop UTIs should have been assessed and care plans had been developed. The director of nursing provided a copy of the facility ' s comprehensive nursing assessment used to evaluate the residents on admission, readmission, significant change, quarterly review, or annual review. The comprehensive nursing assessment directed evaluation of bladder and bowel but did not direct or assist staff to evaluate the resident's risk for developing a urinary tract infection. The comprehensive nursing assessment and reassessment lacked contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment.	{F 315}	communication binder in the break room and/or through their department communication methods by 2/20/2015 with a live in-service planned for nursing and dietary staff members on 3/5/2015. All nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating knowledge of plan as stated above by this same date. Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.	
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	{F 441}		2/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 441}	Continued From page 17	{F 441}		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE** **WINONA, MN 55987**

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{F 441}

Continued From page 18

Based on interview and record review, the facility failed to maintain an infection control program that included surveillance and analyzing and trending data. This has the potential to affect all residents in the facility.

Findings include:

On 1/22/15 a listing of December 2014 infection incidents by unit was provided by the staff. On reading the listing it did not include resident names, room numbers, site/s of infection/s, culture reports if any, staff interventions or resolution of infection/s. The director of nursing was interviewed on 1/22/15 at 9:50 a.m. She stated this was the information she would review and would present to quality assurance committee. The DON stated that no line listing had been completed for January 2014 at this time since the month was not over and these listings were completed after the month was over. However, interventions for infections that may develop at the start of the month were not addressed timely to prevent the spread or to determine staff education is warranted to prevent the infection from spreading or reoccurring. The DON was unable to provide an analysis or trending of the infection incidence data when requested.

The designated infection control nurse (RN)-A provided an antibiotic listing for December 2014 and up to January 22, 2015. This listing was computer generated and did not indicate symptoms for which the antibiotics were given, culture results, interventions or resolutions of infections.
The antibiotic listing from January 1 to January 22, 2015 noted the entire facility received Tamiflu

{F 441}

In response to the above stated citation Sauer Health Care has taken the following action:
" An assessment titled Urinary Tract Infection Risk Assessment was created on 2/17/2015. This assessment will be completed on all residents identified as having frequent or recurrent UTIs as identified by having more than 2 in 6 months or 3 in 1 year. These will be completed by 3/31/2015.
" All other residents will have this assessment completed at admission, and/or with quarterly assessment schedule.
" An audit will be completed to ensure these are being done per the planned schedule.
" Policy titled Urinary Tract Infection (UTI) Identification, Treatment, Prevention and Management that was revised following the initial state survey was reviewed and revised again on 2/17/2015 to include directives to assess for risk and develop interventions based on findings as well as directives on analyzing and trending data for review.
" All staff will be educated on this plan via electronic mailing, paper copy in communication binder in the break room and/or through their department communication methods by 2/20/2015 with a live in-service planned for nursing and dietary staff members on 3/5/2015. All nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating knowledge of plan as stated above by this same date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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{F 441}	Continued From page 19 (antiviral agent given for influenza). The director of nursing was interviewed on 1/22/15 at 9:50 a.m. She stated no resident had a positive laboratory test for influenza, but that a staff member had tested positive so at the medical director recommended the Tamiflu should be used for a preventative measure for the residents. During this same time period three residents identified on the antibiotic line listing had pneumonia/respiratory infections and no influenza testing was noted. At 12:40 p.m. on 1/22/15 RN-A stated these three residents did not have confirmed cases of pneumonia since no radiology results confirmed them. The residents were being treated with antibiotics just to be safe.	{F 441}	Compliance for adherence to this plan will be the responsibility of the nursing department staff members and the infection control nurse with oversight provided by the QA team and overall compliance being the responsibility of the Director of Nursing Services. Additional actions taken not related to the findings listed in the citation. " Following exit of the state survey team much internal investigation took place to identify root cause of current UTI issues, identify risk factors and strategically plan ways for added prevention. o The infection control nurse completed a review of UTI incidence dating back to 2013. ? This review did identify a possible spike in infection rate at mid-year of 2013 " The facility had made a switch in vendors for incontinence products at that time. o A team consisting of three RN staff members completed a review of the reported data. o The facility determined that it would be in the best interests of the residents to switch incontinent products again to see if there is any correlation in these findings. ? The representative from Professional Medical was in the facility on 2/17/2015 working with facility staff members to switch out all current incontinent products with new products.	

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	245102	A. BUILDING ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 441}	Continued From page 20	{F 441}	o The infection control nurse completed research on prophylactic UTI methods and found information on UTI Stat that was shared with the Medical Director. ? He does not wish to implement this process at this time but instead wait to review the success or failure resulting from the above mentioned product switch. ? Medical Director also spent considerable time educating the QA team members on the importance of differentiating between urinary tract infections that require treatment and asymptomatic bacteremia and/or colonized bacteria. " This information has been added to the above mentioned policy. o The current infection issues were shared with the Clinical and Regulatory Compliance Nurse at Professional Medical and she offered some information via email that is being reviewed. ? Many of her suggested actions are already in place at the facility but this information will be kept as a reference to use as needed following findings from product change that is currently being implemented. o The DON and Maintenance Director reviewed the current disinfectant products being used on shared facility items such as commodes, shower chairs etc.. " Peri care is also being considered as a possible contributing factor to the infection rate and as a result of this, all nursing staff has been assigned the EduCare training module Personal Cares. This module includes perineal care for females & males as well as toileting. Staff	

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	245102	A. BUILDING ______ B. WING ______	R **01/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{F 441}	Continued From page 21	{F 441}	is required to complete a skills demonstration assessment and all will have this completed by 4/7/2015.	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245102	01 - MAIN BUILDING 01	1/5/2015

Name of Facility	Street Address, City, State, Zip Code
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	01/04/2015	ID Prefix Reg. # NFPA 101 LSC K0033	01/04/2015	ID Prefix Reg. # NFPA 101 LSC K0062	01/04/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KFD	Date: 01/29/2015	Signature of Surveyor: 25822	Date: 01/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/19/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on February 10, 2015.

February 10, 2015

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

Re: Project # S5102024

Dear Ms. Blair:

On January 22, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 25, 2014 with orders received by you on December 15, 2014.

State licensing orders issued pursuant to the last survey completed on November 25, 2014 and found corrected at the time of this January 22, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on November 25, 2014, found not corrected at the time of this January 22, 2015 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use	**$ 300.00**
20910 -- MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence	**$ 350.00**
21390 -- MN Rule 4658.0800 Subp. 4 A-I -- Infection Control	**$ 300.00**
21805 -- MN St. Statute 144.651 Subd. 5 -- Patients & Residents Of Hc Fac.Bill Of Rights	**$ 250.00**

The details of the violations noted at the time of this revisit completed on January 22, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1200.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below.

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gary Nederhoff, Rochester District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00705	A. Building B. Wing	1/22/2015

Name of Facility	Street Address, City, State, Zip Code
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20285** Reg. # **MN Rule 4658.0100 Subp.** LSC	**01/04/2015**	ID Prefix **20540** Reg. # **MN Rule 4658.0400 Subp.** LSC	**01/04/2015**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp.** LSC	**01/04/2015**
ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	**01/04/2015**	ID Prefix **20850** Reg. # **MN Rule 4658.0520 Subp.** LSC	**01/04/2015**	ID Prefix **20860** Reg. # **MN Rule 4658.0520 Subp.** LSC	**01/04/2015**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	**01/22/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	**01/22/2015**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Sul** LSC	**01/04/2015**
ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	**01/04/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	03/24/1015	31221	01/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/25/2014			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments	{2 000}		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
An onsite follow-up visit was completed on January 21 & 22, 2015. During this onsite visit it was determined there are licensing orders that have not been corrected at the time of this licensing survey. These uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 000}	Continued From page 1 reviewed for possible penalty assessment/s.	{2 000}		
{2 565}	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and document review the facility failed to follow each resident's care plan which was developed based on the comprehensive assessment for 4 of 20 residents (R46, R62, R55, R58) needing staff assistance with eating; the facility failed to follow a hospice care plan for 1 of 1 resident (R14) who had a change in health status and physician had not been contacted timely; lastly the facility failed to follow 1 of 3 residents (R54) care plan addressing personal hygiene needs. Findings include: Lack of providing eating assistance as directed in the care plan: R46, R62, R55, R58 observed on 1/22/15 from 11:05 a.m. to 12:00 p.m. seated at a table designated for residents who needed staff assistance to eat their meals. R46 was observed from 11:10 a.m. to 12:00 p.m.	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 2 and was observed to be sleeping in the wheelchair while R46's food sat in front of her uncovered. No staff was sitting beside her to assist her with eating or to cue her to eat. R46 was observed to keep pushing the wheelchair away from the table and the nurse or nursing assistant would push her back to the table. One staff stood to encourage her to eat and assisted her with cutting the food. R36 ate less than 25% of the meal. The care plan printed 1/22/15 identified self-care deficit. The care plan indicated R46 was able to feed herself, but perhaps needed some assistance to open things, but most items in the dining room were ready to eat. The care plan also indicated staff was to be there to help R46 eat. During an interview at 4:30 p.m. on 1/22/15 the director of nursing (DON) stated R46 was to be cued for eating. The DON stated R46 was able to take a fork to her mouth, but did not always have food on the fork. DON stated NA-A should encourage R46 to eat and that it would be okay to talk to R46 across the table R62 was observed during the lunch meal on 1/22/15 from 11:05 a.m. to 12:00 p.m. R62 made no attempt to feed self. NA-A assisted the resident to eat. NA-A was not observed to provide guidance for eating safely or encouraged to eat or drink. At one point NA-A left R62 and moved over to cut R62 food. The care plan printed 1/22/15 indicated R62 was at a potential for nutritional risk and was to be provided meals at the restorative dining table. The care plan directed staff were to encourage resident to drink, to tuck chin, to sit at 90	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 3	{2 565}		

degrees, to encourage through clearing and double swallow. In another area of the care plan the interventions noted R62 was totally dependent on staff to eat.

During an interview at 4:30 p.m. 1/22/15 the director of nursing (DON) stated R62 was to be totally assisted to eat. The DON stated R62 should not be seated at the restorative table if she is unable to eat independently.

R55 was observed at lunch on 1/22/15 from 11:25 am to 12:00 noon. R55 was being fed by NA-A and made no attempt to feed herself.

The care plan printed 1/22/15 indicated R55 was on the restorative nursing program for eating/swallowing. Staff was to provide cueing to promote independent eating and assistance as needed for task completion. In another area of the care plan identified a problem of self-care deficit and indicated R55 needed extensive assistance for eating and help with the actual eating process. The care plan also directed R55 needed encouragement to eat and needed to be fed.

During an interview at 4:30 p.m. 1/22/15 the director of nursing stated R55 was to be cued for eating.

R58 was observed during the noon meal on 1/22/15 between 11:35 a.m. and 12:00 N. R58 was being fed by NA-A.

The care plan printed 1/22/15 indicated self-care deficit and that R58 needed limited assistance with eating. The care plan interventions indicated R58 needed assistant with set up and cueing and at times needed to be actually fed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{2 565}	Continued From page 4	{2 565}		

NA-A was interviewed at 12:00 noon on 1/22/15. NA-A stated only one person was assigned to help at the restorative nursing table. She added R62 would never feed herself and that R58 had advanced dementia and at times also needed help. NA-A stated R55 and R46 were able to feed self but needed encouragement to do so. During an interview on 1/22/15 at 4:30 p.m. the director of nursing (DON) stated that usually only one staff member was assigned to assist at the restorative table which should have only residents that need a restorative dining program. DON stated she did not know why other staff did not assist

During an interview on 1/22/15 at 4:30 p.m. the director of nursing indicated R58 was to be totally fed. DON stated R58 sat at the restorative table and had a restorative dining program. Staff was to set-up the meal for R58, provides verbal cues, and provided hand over hand assistance as needed. DON stated R58 should have finger foods. DON stated the care plan identified what the facility hoped would be provided and now needed to be updated.

Lack of timely notification of change in condition:

R14's interdisciplinary team (IDT) progress notes dated 1/19/15 at 6:17 p.m. said R14 experienced shortness of breath, sweating, and complained of chest pain and stated, "Help me." The medication administration record (MAR) noted R14 was administered as needed Lorazepam (anti-anxiety medication), three times between 6:40 p.m. and 7:50 p.m. on 1/19/15; as needed Duonebs (respiratory medication) one time; and as needed morphine (narcotic pain medication) twice between 6:10 p.m. and 9:30 p.m. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 5	{2 565}		

review of the MAR indicated R14 had not received as needed morphine, Lorazepam or Duonebs at any other time from January 1, 2015 to January 22, 2015.
The IDT progress note dated 1/19/15 at 6:17 p.m. and it read a nurse had assessed lung and heart sounds, but had not notified the physician, nurse practitioner or hospice nurse with the deterioration of health status. Review of the interdisciplinary progress notes of 1/19/15 through 1/21/15 did not document notification of physician (MD), nurse practitioner (NP), or hospice nurse.

R14's care plan printed 1/22/15 noted a history of myocardial infarction and a history of coronary artery disease (CAD). The interventions directed staff to monitor/document/report to nursing, nurse practitioner or medical doctor of any signs or symptoms of CAD, chest pain or pressure, shortness of breath, or excessive sweating. A hospice form directed that with a change in condition, hospice staff were to be immediately notified. The director of nursing (DON) was interviewed on 1/22/15 at 10:15 a.m. and stated she was unaware of this incident and would check with the LPN who was working that evening. At 12:52 p.m. DON stated the nurse should have completed an assessment prior to the medications and for a trained medication aide (TMA) to give the as needed medications. The DON verified the documentation did not indicate that an assessment was completed before the medications were given. On 1/22/15 at 2:40 p.m. DON stated she did not know if the registered nurse on duty that evening had been notified and verified the documentation did not indicate the physician, nurse practitioner or hospice had been notified as directed in the plan of care. The facility policy Change of Condition, Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 6	{2 565}		

Notification dated 11/11/14 was reviewed. The policy read, "The attending physician or physician/NP on call will be notified with changes in a resident's condition or health status ..." The policy also identified symptoms of shortness of breath and chest pain as changes in condition that were to be reported. The policy procedure also directed the charge nurse or supervisor was to be notified.
Lack of providing nail care as directed on the care plan:

R54 was observed on 1/21/15 at 1:05 p.m. with long white facial hair on the left side of her neck and facial hair on her upper lip.
The quarterly Minimum Data Set dated 12/9/14 indicated R54 had a brief interview for mental status score of 6 which indicated severe cognitive impairment, required limited assistance of one staff with personal hygiene. The care plan dated 9/22/13 indicated R54 had, an "ADL [activity of daily living] Self Care Performance Deficit r/t [related to] her dementia. She needs supervision only with her ADLs." Interventions included, "R54 is able to do her own personal cares, but again needs to be supervised." The nursing assistant flow sheet indicated R54 required supervision with activities of daily living and directed staff to assist with hair care/grooming.

R54's facial hair on her neck and upper lip was verified during an observation by the director of nursing (DON) on 1/21/15 at 2:02 p.m.

On 1/21/15 at 2:06 p.m. the DON verified R54's care plan read, "Is able to do her own personal cares, but again needs to be supervised " and stated this would include facial hair removal. The DON verified the facility did not follow the care plan for personal hygiene for R54.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 7 This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 565}		
{2 910}	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and document review, the facility had not completed a comprehensive reassessment for urinary tract infection (UTI) for 1 of 3 residents (R20) reviewed for recurrent UTIs Findings include:	{2 910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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{2 910}	Continued From page 8	{2 910}		

R20 had a history of recurrent UTIs but lacked a comprehensive reassessment to determine risk factors (what about lack of interventions developed for UTIs) for development of urinary tract infections and based on these assessments interventions were developed to reduce or illuminate the chance of having a UTI.

A comprehensive nursing assessment dated 12/15/14 identified palliative care, dysphagia, and anxiety as diagnoses for R20.

The quarter Minimum Data Set (MDS) dated 12/18/14 identified R20 as having frequent incontinence, needing extensive assistance with toilet use and personal hygiene. The MDS did not identify the resident had an indwelling catheter or a history of having UTIs.

The director of nursing (DON) provided a copy of R20's comprehensive nursing assessment dated 12/15/14. This was reviewed with the DON on 1/22/15 at 3:30 p.m. The form only had questions that were checked yes or no. However, there was not question/s related to having UTIs. There was no analysis of the forms questions marked yes to determine a comprehensive reassessment had been completed. The director of nursing was asked for any other information related to a comprehensive bladder assessment and none was provided.

Review of the undated policy procedure Urinary Tract Infection (UTI) Prevention and Management. However, it did not direct staff to assess resident's risk for UTIs and develop intervention.

During an interview on 1/21/15 at 2:45 p.m. the director of nursing she indicated all residents at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 910}	Continued From page 9 risk to develop UTIs should have been assessed and care plans had been developed. The director of nursing provided a copy of the facility ' s comprehensive nursing assessment used to evaluate the residents on admission, readmission, significant change, quarterly review, or annual review. The comprehensive nursing assessment directed evaluation of bladder and bowel but did not direct or assist staff to evaluate the resident's risk for developing a urinary tract infection. The comprehensive nursing assessment and reassessment lacked contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 910}		
{21390}	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and	{21390}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21390}	Continued From page 10	{21390}		

procedures of resident care practices to assist in the prevention and treatment of infections;

F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;

G. a system for reviewing antibiotic use;

H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and

I. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
This licensing order was not corrected due to:

Based on interview and record review, the facility failed to maintain an infection control program that included surveillance and analyzing and trending data. This has the potential to affect all residents in the facility.

Findings include:

On 1/22/15 a listing of December 2014 infection incidents by unit was provided by the staff. On reading the listing it did not include resident names, room numbers, site/s of infection/s, culture reports if any, staff interventions or resolution of infection/s. The director of nursing was interviewed on 1/22/15 at 9:50 a.m. She stated this was the information she would review and would present to quality assurance committee. The DON stated that no line listing had been completed for January 2014 at this time since the month was not over and these listings were completed after the month was over.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21390}	Continued From page 11	{21390}		

However, interventions for infections that may develop at the start of the month were not addressed timely to prevent the spread or to determine staff education is warranted to prevent the infection from spreading or reoccurring. The DON was unable to provide an analysis or trending of the infection incidence data when requested.

The designated infection control nurse (RN)-A provided an antibiotic listing for December 2014 and up to January 22, 2015. This listing was computer generated and did not indicate symptoms for which the antibiotics were given, culture results, interventions or resolutions of infections.
The antibiotic listing from January 1 to January 22, 2015 noted the entire facility received Tamiflu (antiviral agent given for influenza). The director of nursing was interviewed on 1/22/15 at 9:50 a.m. She stated no resident had a positive laboratory test for influenza, but that a staff member had tested positive so at the medical director recommended the Tamiflu should be used for a preventative measure for the residents. During this same time period three residents identified on the antibiotic line listing had pneumonia/respiratory infections and no influenza testing was noted. At 12:40 p.m. on 1/22/15 RN-A stated these three residents did not have confirmed cases of pneumonia since no radiology results confirmed them. The residents were being treated with antibiotics just to be safe.

This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21805}	Continued From page 12	{21805}		
{21805}	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and document review the facility failed to provide a dignified dining service for 4 of 20 residents (R46, R62, R55, and R58) observed during the dining experience. Findings include: R46, R62, R55, R58 who were dependent on staff for eating assistance were not provided timely and consistent assistance to ensure a dignified dining experience for each resident was provided. Nursing assistant (NA)-A was observed sitting at table with R46, R62, R55, and R58. At 11:44 a.m. NA-A was observed to leave the table R46 attempted to feed self while the other residents remained seated with no attempt to feed self although their food was sitting in front of them. At 11:47 NA-A returned to sit between R62 and R55 and set up drinks for them, then NA-A got up and walked around the table to sit between R58 and R46 to assist them to eat. At 12:03 p.m. R55 and R62 remained sitting at the table not eating or being encouraged by staff to eat the meal. NA-A	{21805}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21805}	Continued From page 13	{21805}		

assisted R46 to place food on the fork. At 12:08 p.m. R55 was observed not to eat and was not being encouraged or assisted to eat. At 12:12 p.m. R62 was sleeping at the table and had not been encouraged to eat. At 12:14 p.m. NA-A was observed to move between R58 and R55 to assist them to eat as they had not been helped or cued to eat for the past 24 minutes. NA-A had not warmed the meal for R58 and R55 before starting to assist them to eat the food.

NA-A was interviewed at 12:00 p.m. on 1/22/15. NA-A stated only one person was assigned to help at the restorative nursing table which included R58, R46, R62, and R55. NA-A said that R62 would never feed herself and that R58 had advanced dementia and at times also needed help. NA-A stated R55 and R46 were able to feed self but needed encouragement to do so. During an interview on 1/22/15 at 4:30 p.m. the director of nursing (DON) stated that usually only one staff member was assigned to assist residents at the restorative table which should have only residents that need a restorative dining program. DON stated she did not know why other staff did not assist when residents needed help.

R46 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R46 was observed from 11:10 a.m. to 12:00 p.m. to be sleeping in the wheelchair while a plate of food was in front of her at the table. No staff was sitting beside her to assist her with eating or to cue her to eat. R46 was observed to keep pushing the wheelchair away from the table and the nurse or nursing assistant would push her back to the table. At one time NA-A stood for a few minutes to encourage her to eat and assisted her with cutting the food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ___ B. WING ___	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21805}	Continued From page 14	{21805}		

R46's care plan printed 1/22/15 identified self-care deficit and indicated R46 was able to feed herself, but perhaps needed some assistance.

During an interview at 4:30 p.m. on 1/22/15 the director of nursing (DON) stated R46 was to be cued for eating.

R62 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R62 was observed during the lunch meal on 1/22/15 from 11:05 a.m. to 12:00 p.m. R62 made no attempt to eat independently. For a short time NA-A assisted the resident to eat and then left R62 to help another resident then came back and was observed to cut R62 food.

R62's care plan printed 1/22/15 indicated R62 was to be provided meals at the restorative dining table and that staff were to encourage the resident to eat.

During an interview at 4:30 p.m. 1/22/15 the director of nursing (DON) stated R62 was to be totally assisted to eat.

R55 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R55 was observed at lunch on 1/22/15 from 11:25 am to 12:00 p.m. and made no attempt to eat independently or with cueing and NA-A assisted her intermittently while going back and forth between two residents.

R55 ' s care plan printed 1/22/15 indicated R55 was on the restorative nursing program for eating/swallowing. Staff was to provide cueing to promote independent eating and assistance as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	R **01/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21805}	Continued From page 15	{21805}		

needed for task completion. In another area of the care plan identified a problem of self-care deficit and indicated R55 needed extensive assistance for eating

During an interview at 4:30 p.m. 1/22/15 the director of nursing stated R55 was to be cued for eating.

R58 did not receive the assistance she needed during the meal service to promote a dignified dining experience. R58 was observed during the noon meal on 1/22/15 between 11:35 a.m. and 12:00 p.m. and received intermittent assistance to eat by NA-A who was helping several residents during the meal service.

R58's care plan printed 1/22/15 indicated self-care deficit and that R58 needed limited assistance with eating.

During an interview on 1/22/15 at 4:30 p.m. the director of nursing indicated R58 was to be totally assisted to eat. DON stated R58 sat at the restorative table and had a restorative dining program. Also DON said that staff was to set-up the meal for R58, provide verbal cues, and provided hand over hand assistance as needed.

This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 27LG
Facility ID: 00705

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245102**
2. STATE VENDOR OR MEDICAID NO. (L2) **493543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAUER HEALTH CARE**
(L4) **1635 WEST SERVICE DRIVE**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/25/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **71** (L18)

13. Total Certified Beds **71** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	71			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 01/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/19/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 15, 2014

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

RE: Project Number S5102024

Dear Ms. Blair:

On November 25, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 4, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 4, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by February 25, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to address cool room complaints timely for 1 of 6 residents (R24) reviewed in the sample on west wing with cold room complaints. Findings include: R24 complained of cold room temperatures. During interview on 11/18/14, at 8:58 a.m., stated the room was cold. R24 stated had reported the cold room to staff. Observations at that time revealed R24's bed was positioned by the	F 166	This plan of correction is being submitted on 12/26/14, one day after due date, this has been ok'd by Gary Nederhoff, MDH supervisor on 12/15/14. In response to the above stated citation Sauer Health Care has taken the following action: " Immediately on 11/19/2014 maintenance staff increased the temperature in the overall building. " Resident (R24) bed has been turned in the room so it no longer sits below the	1/4/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/26/2014

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.

POC NOT FINAL

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	245102	A. BUILDING ______ B. WING ______	11/25/2014

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F 166	Continued From page 1	F 166		

F 166 — Summary Statement of Deficiencies (continued):

window. R24 sat in a wheelchair and R24 was covered with a sweater and blanket.

During environment tour on 11/20/14, at 1:30 p.m., director of environmental services (DES-A) verified the cold rooms for R24. DES-A stated he spot checked room temperatures only if there was a complaint. He stated last week the facility had cold temperature complaints on east wing which he repaired. He stated he was not aware of cold room complaints on west wing.

Document review of facility physical environment policy dated 10/1/09-patient environment: #2. "There is adequate heating system to maintain comfortable temperatures of at least 71 degrees during the heating system."

F 166 — Provider's Plan of Correction (continued):

window.

" Maintenance Director visited with residents including (R24) on 11/19/2014 and did follow up visits on 11/20/2014 & 11/21/2014. Follow up visits concluded resident satisfaction with overall increase in building temperature.

" The policy titled, Grievance Policy dated 2/4/2014 was reviewed and felt to be up to date, no changes were made.

" The policy titled, Physical Environment dated 10/1/2009 was reviewed and felt to be up to date, no changes were made.

" A note stating the following, We encourage resident/family to bring concerns/complaints to facility staff and residents have the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents will be included in the January edition of the facility newsletter.

" Social Services Director met with (R24) on 12/16/2014 related to the temperature of her room, to try to ascertain who she expressed concern to in the past re: her room. And to remind her she can bring any concerns to any staff and if they don t get resolved that she should contact a manager.

" On 11/26/2014 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents overall comfort level including the temperature in the facility.

o Please be asking the residents about

POC NOT FINAL

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F 166	Continued From page 2	F 166	their comfort level when you are working with them and this includes being too hot or too cold in their home. If you feel it is cold in a certain area of the facility please mention it so we can look into it. Until the concern can be addressed, offer the resident additional blankets if they are too cold. " Sauer Health Care board of directors approved on 9/15/2014 the purchase of an automatic temperature control monitoring system for the entire building. Maintenance has begun the process of getting this system installed. " Maintenance staff when notified of a complaint or concern will complete a monitoring of the area indicated in the complaint or concern with use of a portable thermostat to ensure the temperature is within the recommended guidelines and take actions as needed as problems are identified. " Administrator attended resident council on 12/2/2014 and reviewed citations including this one and reminded residents to report any concerns about the temperature to the staff, including the Administrator if need be. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of all Sauer Health Care staff with overall compliance being	

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F 166	Continued From page 3	F 166	the responsibility of the Administrator, Social Service Director and the Maintenance Department Manager.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 2 of 2 residents (R27, R37) who ate in the main dining room and required assistance to eat their meals. Findings include: R27 and R37 were observed during a dining experience on 11/18/14 starting at 8:12 a.m. R27 and R30 were seated across from one another at the same dining room table with nursing assistant (NA)-B sitting in a chair to right of R27. At 8:21 a.m. NA-B was observed to be standing by the side of R37 and assisting her to eat bites of food. At 8:22 a.m. NA-B sat down in the chair by R27 and assisted her to eat her food. At 8:23 a.m. NA-B was observed to leave the table where he was assisting R27 and R37 to eat and was observed to pour another resident sitting at an adjacent table a cup of coffee. At 8:25 a.m. NA-B returned to sit by R27 and resumed assisting her to eat. At 8:30 a.m. NA-B was observed to be standing by R37 assisting her to eat. At 8:33	F 241	In response to the above stated citation Sauer Health Care has taken the following action: " On 11/26/2014 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents dining experience. o Please be aware of the residents dining experience. Make sure there is a staff member present when the food is brought to the table to assist right away for the residents who require assistance to eat. And make sure you are seated when you are assisting the residents. " A coaching/re-education was completed on 11/26/2014 with the staff member who was observed in the dining room. This staff member is a long time employee and was aware of this and had actually approached the DON to report this event prior to the state surveyor. " The facility policy titled, Feeding a	1/4/15

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F 241	Continued From page 4 a.m. NA-B was observed to be standing by the side of R37 assisting her to eat bites of her food and take drinks of her fluids. At 8:35 a.m. NA-B was observed to be sitting down in the chair by R27 assisting her to eat her breakfast. During an interview on 11/18/14 at 12:26 p.m. NA-D verified he was standing by R37 when he assisted her to eat her breakfast. NA-D stated she was a resident that only ate a few bites of food at a time and that was why he did not sit down by her. NA-D also stated he stood by R37 because if he did not get back to R27 quickly, R27 became agitated because you were helping somebody else and she won't eat. NA-D stated there were usually two more residents that sat at this table during meal time and there were usually two staff members at this table assisting residents that sat by each other to eat. NA-D stated R27 stopped eating towards the end of the meal as he had gotten up to many times when he was assisting her to eat to help other residents. R27's nutritional care dated 5/29/13 read, "...has the potential to be at nutritional risk r/t [related to] diagnosis as well as need for staff assistance for all meals as well as varying intakes for these meals... Interventions: ...Staff to assist with all meals ..." The activity of daily living care plan dated 11/2/12 read, "...is totally dependent on two for all of her ADL'S [activities of daily living] This is a normal progression for end stage Lewy body dementia. Interventions: ...needs to be fed. She is totally dependent on one staff for all of her eating." The quarterly Minimum Data Set (MDS) assessment dated 10/30/14 indicated R27 required extensive assist of 1 staff for eating. The nutritional assessment dated 7/11/14 read, "...FEEDING: Extensive or total assistance with	F 241	Dependent Resident dated 11/6/2013 was reviewed and felt to be up to date with the current regulations. " Random audits of the dining experience will be completed at the discretion of the DON to assess the environment for compliance. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as certified nursing assistants and dietary staff members with overall compliance being the responsibility of the Director of Nursing Services.	

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	245102	A. BUILDING ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 5 eating or drinking." R37's nutritional care dated 8/22/14 read, "...has the potential to be at nutritional risk d/t [due to] advanced dementia m/b [may be] need for therapeutic diet as well as mechanically altered diet consistency per MD [medical doctor] order as well as varying intakes for all meals ... Interventions: Encourage [R37] to feed herself, and then assist with feeding when resident does not feed herself ..." The activity of daily living care plan dated 9/19/14 read, "... has an ADL [activity of daily living] Self Care Performance Deficit r/t [related to] impaired cognition and decreased functional status m/b [may be] requiring staff assistance with all ADLs... Interventions: ...requires extensive assistance of one staff with her meals. She needs encouragement to eat and will sometimes need to be fed (total) as she seems not to know what to do with the silverware on certain, less aware, days." The quarterly Minimum Data Set (MDS) assessment dated 10/28/14 indicated R37 required extensive assist of 1 staff for eating. The nutritional assessment dated 6/25/14 read, "...FEEDING: Able to feed herself ... Summary...is assisted in the dining room with meals." During an interview on 11/20/14 at 2:34 p.m., the director of nursing stated she expected staff to be seated next to residents in the dining room when assisting them to eat their meals. The DON verified it was a dignity issue to stand by a resident and assist them to eat their meal. The Feeding a Dependent Resident policy dated 11/6/13 read, "6. Tell the resident that you are going to be seated during the feeding, staff is to position a chair where it will be convenient for	F 241		

POC NOT FINAL

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F 241	Continued From page 6 both them and the resident."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide choices regarding bathing frequency for 1 of 3 residents (R70) reviewed for choices. Findings Include: R70's annual Minimum Data Set (MDS) dated 10/9/14, identified but not limited to diagnoses of Aphasia (unable to communicate accurately), cerebrovascular accident, atrial fibrillation and required physical help in part of bathing of one person physical assist. R70's brief interview for mental status (BIMS) score of twelve indicated moderate cognitive impairment. R70's plan of care (POC) dated 8/6/2014, read, "... has an actual self-care deficit as related to his CVA [cerebrovascular accident] with right sided hemiplegia ...Interventions ...needs the extensive assistance of one for bathing. He may be able to do some tasks, but limited as his dominant hand is not functioning due to his CVA [cerebrovascular	F 242	In response to the above stated citation Sauer Health Care has taken the following action: " On 11/26/2014 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the resident s right to participate in the design of their care plan. o When you are providing a shower or bath to the residents please be asking the ones who are able to communicate their needs to us if they are satisfied with the current time and number of baths they are being offered. If a resident expresses a desire to change the time or number of baths they receive then notify the charge nurse and/or social services so this can be addressed. " The resident identified in this citation has been approached by staff to question their preference on bathing and schedule	1/4/15

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F 242 Continued From page 7

accident]. His shower day is Monday in the PM [evening] ..."

R70 was interviewed on 11/18/2014 at 12:06 p.m., when asked, "Do you choose how many times a week you take a bath or shower?" R70 responded, " No! " and indicated one with his finger to answer how many times a week he had a shower or a bath. When asked if he would like more than one shower or bath a week, R70 shook his head indicating yes and indicated he would like three by holding up three fingers. When asked if he had told staff he would like more than one shower or a bath each week R70 shook his head yes.

During an interview on 11/21/14, at 11:18 a.m., registered nurse (RN)-B stated it was standard in the facility for bathing one time a week unless a resident requested additional baths or we have a physician order specifying bathing frequency. RN-B stated the bathing schedule was based on room location unless there was a specific request or preference based on evening or morning. RN-B stated when I visit with residents upon admission, I let them know their shower or bath is on a specific day. RN-B stated I instruct residents about our bathing process informing them baths are provided one time a week, with sponge bathing twice a day. RN-B stated I inform residents they just need to let staff know if they would like additional baths and stated the facility will accommodate requests. RN-B stated she spoke with R70 regarding his preference for bathing frequency and R70 will be scheduled for bathing two times per week per their conversation.

A policy for bathing choices was requested and

F 242

has been adjusted accordingly to offer twice weekly bathing.

" On 11/28/2014 a CNA staff member completed an audit of all current residents to address bathing preferences. All current residents who are able to express their wishes were asked about bathing preference and the current bathing schedule was reviewed. The residents were then asked if they were satisfied with the frequency and time of their current schedule and the bathing schedule was adjusted accordingly for any resident who expressed dissatisfaction.

" The current Comprehensive Nursing Assessment in use was modified on 12/10/2014 to include a section related to resident preferences. This section will now include asking questions about bathing preferences. Resident bathing will then be completed based on these indications.

" Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address.

" Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015.

" Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015.

Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as certified nursing assistants with overall

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F 242	Continued From page 8 not provided.	F 242	compliance being the responsibility of the Director of Nursing Services.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		1/4/15

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive sleep assessment to determine interventions to control insomnia for 1 of 1 resident (R91) admitted to the facility with a diagnosis of insomnia and receiving a sleep medication. Findings include: R91 was not comprehensively assessed for insomnia according to the Minimum Data Set requirements for all residents admitted to the facility. R91 was admitted to the facility 11/3/14 and had diagnoses as listed on the physician orders as acute kidney failure, diabetes, anxiety, depression, and insomnia. The CAA (care area assessment) text note dated 11/14/14 indicated R91 had a BIMS (brief interview for mental status) of 8 out of 15 or moderately impaired, and PHQ-9 score of 1 indicating minimal depression and included a diagnosis of progressive dementia. R91 had physician orders dated 11/3/14 for diazepam (Valium) at bedtime for anxiety, and Trazodone (antidepressant used out of class as a sleeping aide) at bedtime for insomnia The CAA note text dated 11/14/14 identified these medications, but did not include an assessment for sleep or interventions to help R91 attain sleep	F 272	In response to the above stated citation Sauer Health Care has taken the following action: " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations. " The care plan for resident (R91) was reviewed and modified on 12/16/2014 to include monitoring sleep, side effects of medication and also the addition of possible non-pharmacological interventions that could be used to elicit sleep. " Sleep monitoring was set up for resident (R91) to assess for any issues or concerns related to sleep and medication use. Alternative interventions for sleep have been put in place. " The sleep section of the Comprehensive Nursing Assessment for (R91) was modified on 12/10/2014 to indicate her use of medicinal sleep aids, diagnosis of insomnia and a noted issue related to sleep as well as the need for sleep monitoring. " The Comprehensive Nursing Assessment was modified on 12/10/2014 to include a trigger for needed sleep monitoring and assessment based on resident history, diagnosis and/or medication use.	

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F 272	Continued From page 10 without medication. The CAA list of factors that could cause or exacerbate the behaviors did not identify sleep disturbances. The facility's Comprehensive Nursing Assessment for admission effect 11/3/14 did not identify a sleep disturbance or behavior/mood symptoms/behaviors or interventions for managing the insomnia or behavioral symptoms. Registered nurse (RN)-B was interviewed on 11/21/14 at 10:50 a.m. RN-B stated it was not necessary to look at the medications for anxiety, insomnia and depression for 3 months according to regulations. RN-B noted the facility monitored R91's sleep pattern.	F 272	" The current MDS Coordinator who was newly hired on 10/17/2014 has received training for MDS Basics at Pathway Health Services. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff with overall compliance being the responsibility of the Director of Nursing Services.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		1/4/15

POC NOT FINAL

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F 278	Continued From page 11 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess an unstageable pressure ulcer on the initial comprehensive skin assessment, for 1 of 2 residents (R28) who were admitted with current pressure ulcers. Findings include: R28 had been admitted on 7/3/14. R28's admission Minimum Data Set (MDS) dated 7/9/14 identified but not limited to diagnoses of a stage II pressure ulcer present on admission. The care area assessment dated 7/16/14 read, "...has a stage II pressure ulcer on her left lateral ankle ..." However, the nursing assessment dated 7/3/14 noted scabbed area and the coding for scabbed area is considered and unstageable ulcer due to not knowing how deep or extensive the ulcer may be. Comprehensive Nursing Assessment dated	F 278	In response to the above stated citation Sauer Health Care has taken the following action: " The care plan for resident (R28) was reviewed on 12/16/2014 and does contain interventions addressing a risk for skin integrity impairment which is felt to be adequate at this time as the pressure ulcer that was present at the time of admission has been noted as healed. " All nursing staff has been provided with a copy of the educational documents titled, Pressure Ulcer Stages/Categories and Pressure Ulcers: Just the facts from The National Pressure Ulcer Advisory Panel (NPUAP). " Discussion is taking place between the DON and the wound consultant nurse from American Medical Technologies (AMT) who comes to the facility monthly for wound services about providing some	

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F 278 Continued From page 12

7/3/14 read, " Site 48) Left ankle (outer): Scabbed area Length: .75, Width: .6, Depth: Not identified, Stage I. Site 48) Left ankle (outer): Other (specify) red/blanching Length: 2, Width: 9. Comments: Site 48 has been covered with foam dressing."

The Wound Assessments: Ulcer Information forms dated and implemented on 7/16/14 indicated the initial stage of the pressure ulcer at the time ulcer was first identified, was a stage II pressure ulcer to the left lateral malleolus.

Skin/Wound Nurse progress noted dated 7/4/14 read, "...reported to observe a scabbed area on resident's left outer ankle. The area: 2 x 3 cm [centimeter] of redden area with a scab in the center 0.75 x 0.6 cm. A foam pad was applied, comprehensive assessment updated, skin flow sheet modified and TAR [treatment administration record] updated. She reports no pain at this time."

Weekly MDS summary progress note dated 7/11/14 read, "...Staff monitors placement of foam boarded dressing to right ankle, which prevents [sic-presents] [as] a scabbed area encircle with reddened skin ..."

Skin/Wound Nurse progress noted dated 7/16/14 read, "...Staff reported a wound to R28's left lateral malleolus. Upon assessment, there was an ulcer present with a thick yellow slough in the center. Area was cleansed, and all sloughs was removed to reveal a pink/white wound bed measuring 0.5 cm x 0.8 cm with a 0.2 cm depth. It had minimal serous drainage. Upon admission, there was a scab noted in this location. Staff report that R28 prefers to sleep on her left side as well, likely causing pressure to this area. Have

F 278

additional onsite education for licensed staff. A date for this is yet to be determined.

o A hand held tablet from EASY Systems was provided to the facility by the AMT wound nurse. This tablet has educational materials built in as well as a built in secure video communication package allowing for ongoing staff training as well as access to the AMT wound nurse as needed to assist with evaluations for staging and treatment guidance.

" The current policies for skin care and pressure ulcers are being reviewed with modifications being made as felt to be needed.

" The current MDS Coordinator who was newly hired on 10/17/2014 has received training for MDS Basics at Pathway Health Services.

" Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address.

" Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015.

" Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015.

Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as the MDS Coordinator with overall compliance being the responsibility of the Director of Nursing Services.

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 278		F 278		

Continued From page 13

provided R28 with vascular boots and they should be worn at all times when she is in bed to prevent pressure to the area. Have consulted AMT [American medical technologies] nurse for advice on treatment."

Medication Administration progress noted dated 8/10/14 read, "Monitor ulcer to left lateral malleolus QOD [every other day], and document on ulcer tracking form. Area scabbed."

Medication Administration progress noted dated 8/10/14 read, "No ulcer remains. No scab. Area where scab was is slightly discolored. Resolving documentation. Will continue with Betadine painting until area is healed."

Skin/Wound Nurse progress noted dated 8/23/14 read, "Left lateral malleolus healed, D/C [discontinue] tx [treatment] per order/ Will con't [continue] to monitor area on bath day "

On 11/20/14 at 1:45 p.m. registered nurse (RN)-B stated a pressure ulcer that presents with a scab would be unstageable as you are unable to tell what the area beneath the scab looks like. RN-B verified the admission MDS dated 7/9/14 was coded inaccurately as a stage II pressure ulcer and stated the MDS should have been coded as an unstageable pressure ulcer because of the scabbed area.

During an interview on 11/20/14 at 2:46 p.m. the director of nursing (DON) verified R28's initial skin assessment should have indicated an unstageable pressure ulcer on the left outer ankle present on admission. The DON also stated the Wound Assessment: Ulcer Information forms should have indicated an unstageable pressure

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F 278	Continued From page 14 ulcer to the left lateral malleolus present on admission. The DON verified the admission MDS should have been coded as an unstageable pressure based on the documentation in the medical record. Pressure ulcer risk assessment policy dated 2/3/09 read, "...6. Documentation of the pressure ulcer will be done a minimum of weekly. 7. All residents with pressure and non-pressure ulcers will be reviewed in the interdisciplinary meeting (IDT) twice a week. 8. The interdisciplinary wound committee will monitor and audit resident treatment plan monthly."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		1/4/15

POC NOT FINAL

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F 279 Continued From page 15

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to develop a plan of care related to monitoring for signs and symptoms related to the resident's medical diagnosis which includes medication use, diet and fluid restriction for 1 of 5 residents (R39) reviewed for unnecessary medications.

Findings include:

R39 was observed on 11/18/14 at 10:55 a.m. sitting in a wheelchair with feet on floor. R39's wife stated R39 had been in the facility for two months because she was unable to care for him at home.

R39 was readmitted to the facility on 10/24/14 and had diagnoses listed on the physician orders dated 10/24/14 as chronic kidney disease, gout, coronary atherosclerosis, paralysis agitans (Parkinson's) , hypertonicity of bladder, hypertrophy prostate, long-term use of anticoagulants, hypertension, depression, dementia.

R39's physician orders included: fluid restriction, low sodium/low cholesterol diet. Medications including aspirin and Coumadin, Detrol for hypertonicity of bladder, Flomax, for hypertrophy prostate, torsemide and Zestril diuretics for congestive heart failure.

R39's care plan printed 11/21/14 was reviewed. The care plan did not include problems or interventions to direct staff related to the diet and fluid restrictions, gout, the use of medications for

F 279

In response to the above stated citation Sauer Health Care has taken the following action:
" On 11/26/14 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents need for an individualized plan of care addressing their specific needs.
o As you are completing your care plan reviews make sure that we have addressed all dx and medications that are in place for that resident to be sure we are making the care plans as individualized possible.
" The care plan for resident (R39) was revised on 12/17/2014 to identify diagnosis, medication use and diet and fluid restriction as identified in citation.
" The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations.
" A random audit of care plan topics, goals and interventions will be completed at the discretion of the DON to ensure individualization is in place.
" Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address.
" Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care

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SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE** **WINONA, MN 55987**

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F 279	Continued From page 16 bladder and prostate issues or diuretic use except to identify incontinence. The care plan did not include the use of Coumadin and aspirin and risk for bleeding in which the nursing aides need to be alerted to in case of bleeding or other symptoms that need immediate interventions. The facility's policy dated 3/3/14 entitled Care Plans-Comprehensive noted an "individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, nursing, mental and psychological needs is developed for each resident." The director of nursing (DON) was interviewed on 11/25/14 at 9:57 a.m. and verified the care plan did not include possible side effects related to medications for anticoagulants, high blood pressure, depression, special diet and fluid restrictions.	F 279	information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as the MDS Coordinator and other departments who develop any section of the care plan with overall compliance being the responsibility of the Director of Nursing Services.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		1/4/15

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F 280	Continued From page 17 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include personal hygiene of shaving for 1 of 1 residents (R65) with long facial hair. Findings include: R65 was observed on 11/18/14 at 9:00 a.m. and 11/25/14 at 9:40 a.m. with long facial hair on her chin and neck. The annual Minimum Data Set dated 10/21/14 indicated R65 required extensive assistance of one staff with personal hygiene. The care plan dated 10/21/14 indicated R65 was able to perform some of her own personal hygiene following staff assistance with set up. The care plan did not indicate if R65 needed assistance with shaving or obtaining a razor. The nursing assistant flow sheet indicated R65 required assist of one with activities of daily living. The flow sheet did not indicate the need for shaving of facial hair. The facility policy dated 3/3/14 entitled Care Plans-comprehensive read, "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans."	F 280	In response to the above stated citation Sauer Health Care has taken the following action: " On 11/26/14 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents need for an individualized plan of care addressing their specific needs. o We need to be sure that shaving is addressed in the care plans under the ADL section of our care plans. (West Unit RN, you need to add this for (R65) immediately) if she does it independently or refuses to allow us to do it then that too needs to be indicated in her care plan. " The resident identified in this citation was provided with shaving immediately when this was brought to the attention of the DON. " Following the above noted email the unit manager revised the care plan for resident (R65) as follows on 11/26/2014. o Resident likes to take care of her own personal needs of shaving her facial hair and is able to perform this independently. Staff should examine the need to be shaved on her shower days and	

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F 280	Continued From page 18 The director of nursing (DON) was interviewed on 11/25/13 at 10:03 a.m. DON stated care plan and nursing assistant flow sheet should address the issue of shaving.	F 280	encourage/remind resident to perform this task. However, given the fact that resident is alert and oriented and staff may remind or encourage her to complete this task, resident at times may refuse to complete this task. " The CNA flow sheets were updated for (R65) on 12/18/2014 to direct CNA staff to remind resident to shave or offer the service to her and to report refusals. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations. " An audit to evaluate the presence of unwanted facial hair was completed on 12/9/2014. " A random audit of facial hair will be completed at the discretion of the DON to ensure shaving of all unwanted facial hair is done for all residents. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for personal hygiene for nail care for 1 of 3 residents (R31) reviewed for activities of daily living. Findings include: R31 had been admitted on 5/15/14. R31's quarterly Minimum Data Set (MDS) dated 10/30/14, identified but not limited to diagnoses of dementia and required extensive assist of one person for personal hygiene. During observation on 11/18/14, at 10:17 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown debris observed underneath on four of the five fingernails. On 1/20/14 at 10:31 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown debris observed underneath the same four fingernails. R31's care plan dated 6/24/14, identified problem: self-care deficit related to dementia with interventions of but not limited to totally dependent on one staff for bathing, needs extensive assist of one staff for personal hygiene.	F 282	In response to the above stated citation Sauer Health Care has taken the following action: " On 11/26/14 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents need for an individualized plan of care addressing their specific needs. o We need to be sure we are providing nail care to all of the residents. This is a question that is asked on the bath day but we need to be sure we are providing this service as needed and not just during the resident s bath. I had HUC buy some nail brushes to make this process quicker and easier to complete. There should be one in each shower room so, if there is not one available let me know and we will replace it. " The resident identified in this citation was provided with nail care immediately when this was brought to the attention of the DON. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations.	1/4/15

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F 282	Continued From page 20 During an observation on 11/21/14 at 10:27 a.m., nursing assistant (NA)-A verified the dirty fingernails on R31's right hand. NA-A stated staff clean residents fingernails on their bath days during bathing and as needed. NA-A stated she would take care of cleaning R31's fingernails today. During an observation on 11/21/14 at 10:28 a.m., registered nurse (RN)-B verified the dirty fingernails on R31's right hand and stated they needed to be cleaned. RN-B stated staff was to clean R31's fingernails on her bath day and as needed. RN-B stated R31 had her bath day on Wednesday in the morning. During an interview on 11/21/14 at 10:44 a.m. the director of nursing stated she expected all resident fingernails to be cleaned on their bath day and stated staff should clean resident fingernails as needed as a part of their daily cares. During an interview on 11/21/14 at 11:30 a.m., the DON stated she considered ensuring clean fingernails would be included in providing extensive assist of one for personal hygiene and verified the care plan had not been followed for R31. A policy was requested for following the comprehensive care plan at this time and one was not provided.	F 282	" An audit to evaluate the cleanliness of resident finger nails was completed on 12/5/2014. " A random audit of resident finger nail cleanliness will be completed at the discretion of the DON to ensure this service is completed for all residents. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.	
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical	F 310		1/4/15

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F 310	Continued From page 21 condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to include facial hair removed per resident request for 1 of 1 resident (R65) observed with facial hair. Findings include: R65 was observed on 11/18/14 at 9:00 a.m. with long facial hair on her chin and neck. R65 stated she would generally have them shaved, but that the razor was dull. The facial hair was gray and about an inch in length. On 11/25/14 at 9:40 a.m. R65 was observed to have facial hair on the chin and neck. The resident commented "Oh do I have it again" in regards to the question about the long chin hair. R65 stated staff use their own razor and she would forget to tell them to shave her. R65 stated it bothered her if the facial hair was long. The annual Minimum Data Set dated 10/21/14 indicated R65 required extensive assistance of one staff with personal hygiene. The care plan dated 10/21/14 indicated R65 was able to perform some of her own personal hygiene following staff assistance with set up. The nursing assistant flow sheet indicated R65 required assist of one with activities of daily living. Neither the care plan or flow sheet did not indicate the need for shaving of facial hair.	F 310	In response to the above stated citation Sauer Health Care has taken the following action: " On 11/26/14 the following memo was sent to the nursing staff from the DON via email as a reminder and introduction of the education planned on the need to be aware of the residents need for an individualized plan of care addressing their specific needs. o We need to be sure that shaving is addressed in the care plans under the ADL section of our care plans. (West Unit RN, you need to add this for (R65) immediately) if she does it independently or refuses to allow us to do it then that too needs to be indicated in her care plan. " The resident identified in this citation was provided with shaving immediately when this was brought to the attention of the DON. " Following the above noted email the unit manager revised the care plan for resident (R65) as follows on 11/26/2014. o Resident likes to take care of her own personal needs of shaving her facial hair and is able to perform this independently. Staff should examine the need to be shaved on her shower days and encourage/remind resident to perform this	

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F 310	Continued From page 22 The director of nursing (DON) was interviewed on 11/25/13 at 10:03 a.m. and stated the nursing assistants were to have a resident shaved as part of the morning cares.	F 310	task. However, given the fact that resident is alert and oriented and staff may remind or encourage her to complete this task, resident at times may refuse to complete this task. " The CNA flow sheets were updated for (R65) on 12/18/2014 to direct CNA staff to remind resident to shave or offer the service to her and to report refusals. " Social Services Director spoke with Resident (R65) daughter on 12/16/2014 to address the resident s report of her razor being dull. Daughter reported that she would purchase a new razor and drop it off at the facility. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations. " The above noted policy will be reviewed with all staff. " An audit to evaluate the presence of unwanted facial hair was completed on 12/9/2014. " A random audit of facial hair will be completed at the discretion of the DON to ensure shaving of all unwanted facial hair is done for all residents. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at	

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F 310	Continued From page 23	F 310	QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the nursing department staff members with overall compliance being the responsibility of the Director of Nursing Services.	
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess urinary tract infection (UTI) risk and develop an individualized plan of care for 5 of 5 residents (R51,R14, R78, R8, R20) with a history of recurrent urinary tract infections. Findings include: R51 developed urinary tract infections on 4/24/14, 5/13/14, 6/27/14, 8/29/14, and 9/12/14. On 9/13/14 R51 was diagnosed with Septicemia due to gram negative organism and urinary tract infection resulting in hospitalization and	F 315	In response to the above stated citation Sauer Health Care has taken the following action: " The Bowel & Bladder section of the Comprehensive Nursing Assessment was modified on 12/10/2014 to include a question about a history of frequent or recurring UTI s. If this is indicated it will trigger the nurse to create a care plan addressing UTI Risk. These assessments are completed at admission, quarterly and at any time of a noted change of condition. " Care plan for (R8) was not reviewed	1/4/15

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F 315	Continued From page 24 intravenous antibiotics. Review of the hospital history and physical (H & P) dated 9/13/14 R51 had been admitted to the hospital related to septic shock with E coli bacteremia from a complicated UTI in January 2014. The H & P (history and physical) indicated R51 had also been seen in the emergency room on 8/26/14 and diagnosed with a UTI. The hospital history and physical dated 9/13/14 was reviewed. R52 was admitted to the hospital related to septic shock secondary to infection and stated R51 was displaying signs of end organ damage from the shock. The H & P indicated UTI was a recurrent problem. The H & P also indicated acute kidney injury related to the sepsis, hypotension, and need for aggressive hydration. The facility's comprehensive nursing assessment for R51 dated 11/12/14 was provided and reviewed. The assessment noted a bowel and bladder screener indicated R51 was incontinent of bladder and stool, had terminal end stage medical issues including prostate cancer, had a catheter and a history of frequent UTIs, The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors related to catheter use, contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment. R51's plan of care printed 11/25/14 included a focus of " was hospitalized with urosepsis with bacteremia, history of MRSA (methylene resistant staphylococcus aureus) in urine that the nurse practitioner on 3/25/14 noted R51 was likely colonized, and had an in dwelling catheter related to prostate cancer. The interventions directed	F 315	or modified as resident is no longer in the facility, having been discharged or expired. " Care plan for (R14) has been reviewed and modified as of 12/11/2014 and 12/19/2014 to include interventions for infection prevention. " Care plan for (R20) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " Care plan for (R51) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " Care plan for (R78) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations. " The facility policy titled, Urinary Tract Infection (UTI) Prevention and Management dated 2/3/2009 has been modified as of 12/19/2014. New policy title, Urinary Tract Infection (UTI) Identification, Treatment, Prevention and Management will be reviewed for approval at the QA meeting on 1/13/2015. Implementation or further modification to be made following that meeting. " A random audit of care plan topics, goals and interventions will be completed at the discretion of the DON to ensure individualization is in place. " The 13 page document titled, Guideline for the Diagnosis and	

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F 315 Continued From page 25

staff to change the catheter and observed for signs of a UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R14 developed urinary tract infections on 6/9/14, 7/17/14, 8/14/14, 9/12/14 and lacked interventions to prevent more UTIs from developing.

The facility's comprehensive nursing assessment dated 9/23/14 noted infrequent incontinence of bladder, predisposing factors for incontinence and a bowel ostomy. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment.

R14's care plan printed 11/25/14 indicated R14 was frequently incontinent of urine, but lacked interventions related to approaches to help minimize the risk of recurent UTIs.

R78 developed urinary tract infections on 5/2/14, 6/16/14. On 6/12/14 R78 was also diagnosed with C-Diff (Clostridium difficile (klos-TRID-e-um dif-uh-SEEL), often called C. difficile or C. diff) infection according to the infection control log.

The facility's comprehensive nursing assessment dated 9/17/14 indicated R78 was occasionally incontinent, had a catheter that would occasionally leak. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors related to catheter use, contributing factors or co-morbidity related to medical conditions,

F 315

Management of Urinary Tract Infections in Long Term Care from TOP (Toward Optimized Practice Program). This document includes the Clinical Pathway. Pieces of this document will be used in providing training to staff.

" Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address.

" Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015.

" Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015.

Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as the MDS Coordinator and Infection Control Nurse with overall compliance being the responsibility of the Director of Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 26	F 315		

cognitive function, medications, or assessments of factors that could lead to septicemia and bacteremia.

R78 had a care plan printed 11/25/14 that indicated a diagnosis of neurogenic bladder and chronic indwelling catheter. The interventions directed staff to change the catheter and observe for signs of a UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R8 developed urinary tract infections on 6/15/14, 10/20/14 and lacked interventions to reduce UTIs.

The comprehensive nursing assessment dated 9/5/14 indicated R8 was occasionally incontinent of bowel and bladder and had no untreatable predisposing incontinence risk factors. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications.

The plan of care printed 11/25/14 indicated a longstanding history of urinary frequency and urgency and directed staff to monitor for signs of urinary tract infections. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R20 developed urinary tract infections on 4/29/24, 8/5/14 and lacked interventions to prevent recurrence of UTIs.

The comprehensive nursing assessment dated 9/12/14 indicated R20 was occasionally incontinent, was independent with toileting and

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	245102	A. BUILDING ______ B. WING ______	11/25/2014

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F 315	Continued From page 27 had no predisposing factors for incontinence. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment. The plan of care printed 11/25/14 had a focus of longstanding diagnosis of stress incontinence and interventions to identify signs of UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs. The director of nursing was interviewed on 11/25/14 at 2:30 p.m. She indicated the comprehensive nursing assessments and care plans were completed on each resident. She stated no other assessments related to urinary tract infection risks or individualized care plans to minimize the risk of recurrent infections had been completed. The facility policy entitled Urinary Tract Infection (UTI) Prevention and Management dated 2/3/09 did not direct nursing staff to assess a resident for the risk of developing urinary tract infections and did not direct the development of an individualized care plan to assist staff with approaches to him minimize the risk of recurrent urinary tract infections.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		1/4/15

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F 371	Continued From page 28 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerator shelving in 2 of 2 walk in coolers was maintained in a clean and sanitary manner. This had the potential to affect all 62 residents in the facility that had been provided food prepared and distributed from the facility kitchen. Finding Include: During the initial kitchen tour on 11/17/14, at 6:10 p.m., with cook (C)-A the walk-in dairy cooler was observed to have 6 out of 18 shelves with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. The second walk-in cooler was observed to have 15 out of 23 shelves observed with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. On 11/17/14 at 6:17 p.m. C-A verified the identified shelves in the walk-in coolers had areas with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. Cook-A verified the cleaning schedule indicated the floors of the walk-in coolers were to be cleaned on Wednesdays and verified the cleaning schedule did not include cleaning the shelving in the walk-in coolers.	F 371	In response to the above stated citation Sauer Health Care has taken the following action: " The shelving in the coolers was cleaned with Sanotracin RTU product and food that was not in a sealed manufacturer s container was disposed of on 11/17/14 by 11:15 pm when this issue was noted by the survey team. " RD was notified of the above citation on 11/18/2014 via email. " Education to all dietary staff on how to clean the coolers and changes to the cleaning schedule was started on 11/18/2014 and completed on 12/11/2014. " The schedule for cleaning and monitoring the cooler spaces was updated as of 11/24/2014. " Policy titled, General Sanitization of Kitchen was reviewed by Dietary manager and RD, no changes made. " All dietary staff will be scheduled to receive education via webinar from Reinharts. To be completed by 1/4/2015. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an	

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F 371	Continued From page 29 During a kitchen observation on 11/17/14, at 8:50 p.m., with another surveyor and the certified dietary manager (CDM), the CDM verified the six identified shelves in the walk-in dairy cooler and the fifteen identified shelves in the second walk-in cooler had areas with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. The CDM stated the areas of concern on the identified shelving in the walk-in coolers were mold. The CDM verified the shelving in the walk-in coolers was not listed on the daily Cleaning Schedule in the kitchen. During an interview on 11/18/14, at 7:45 a.m., the administrator stated the refrigerators have been cleaned. The administrator stated she reviewed the policy and verified the policy/procedure does not specifically list cleaning of the shelves in the walk-in coolers. During a kitchen observation and interview with the CDM on 11/18/14, at 8:47 a.m., the dairy walk-in cooler was observed to have been cleaned and had eighteen shelves in the cooler. The second walk-in cooler was observed to have been cleaned and had only 16 out of the 23 shelves initially observed in the cooler. The CDM stated some of the shelving from the second walk-in cooler was going to be replaced because of its condition. The CDM stated Asbesbegon (an abatement contractor) company was contacted last night by maintenance for a recommendation on how to clean the walk-in coolers because of the mold concern. The CDM stated the shelving in both walk-in coolers was power washed, all the shelves, the walls and flooring was cleaned with Sanotracin RTU, a mold killing chemical recommended by Asbesbegon. The CDM stated she completed audits of the kitchen areas but	F 371	in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the dietary department staff along with the maintenance department with overall compliance being the responsibility of the Dietary Department Manager.	

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F 371	Continued From page 30 apparently not well enough because the mold on the shelves in the walk-in coolers was missed. The CDM stated she had a staff meeting this morning and discussed the need for staff to be aware of cleanliness in the kitchen. The CDM stated, "I don't know what to say. I am upset this happened. There is nothing I can say. It should not have happened." The CDM stated all kitchen staff will be re-educated on maintaining a clean and sanitary kitchen and the daily cleaning schedule will be revised to include the shelving in the walk-in coolers. During an interview on 11/18/14 at 9:34 a.m., the director of nursing (DON) stated she reviewed the documentation of tracking and trending of staff illness in the kitchen and there was no correlation between staff illness that can be related to the mold found in the kitchen walk-in coolers. The General Sanitation of Kitchen policy dated 12-7-11 read, "The Dietary Services staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Procedure: 1. Cleaning and sanitation tasks for the kitchen will be recorded. 2. Tasks will be assigned to be the responsibility of specific positions per cleaning schedule. 3. Tasks will be addressed as to frequency of cleaning. 4. A cleaning schedule will be posted and employees will initial and date tasks when completed ..."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		1/4/15

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F 441	Continued From page 31	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

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F 441	Continued From page 32 Based on interview and document review the facility failed to identify recurrent urinary tract infections (UTI), monitor and tract symptoms, monitor and analyze data to minimize the risk of recurrent UTIs and the facility failed to provide staff education for 5 of 5 residents (R51, R14, R20, R8 and R78) with recurrent urinary infections and for these 17 additional residents ((R19, R67, R25, R38, R5, R44, R59, R75, R12, R64, R31, R56, R55, R6, R87, R999 and R87) identified by the facility on the infection logs between April and October 2014. Findings include: R51 developed 5 urinary tract infections between April 24, 2014 and September 12, 2014. R51 had an indwelling catheter. Documentation completed by the infection control nurse indicated R51 would display one symptoms indicating a possible UTI (behaviors, confusion, agitation, blood pressure changes). On two occasions 2 symptoms were identified. The micro-organism was identified for three of the infections and each culture identified the same micro-organism. Two different antibiotics were identified used for the same micro-organism. R14 developed 4 urinary tract infections between June 2014 and September 2014. Documentation completed by the infection control nurse indicated R14 had displayed only falls for 2 of the infections. The June infection documentation indicated 3 symptoms and the other infection documentation indicated 2 symptoms had been identified. Two different micro-organisms had been identified for the four infections. In June the infection control nurse noted the culture results were probably	F 441	In response to the above stated citation Sauer Health Care has taken the following action: " The Bowel & Bladder section of the Comprehensive Nursing Assessment was modified on 12/10/2014 to include a question about a history of frequent or recurring UTI s. If this is indicated it will trigger the nurse to create a care plan addressing UTI Risk. These assessments are completed at admission, quarterly and at any time of a noted change of condition. " Care plan for (R8) was not reviewed or modified as resident is no longer in the facility, having been discharged or expired. " Care plan for (R14) has been reviewed and modified as of 12/11/2014 and 12/19/2014 to include interventions for infection prevention. " Care plan for (R20) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " Care plan for (R51) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " Care plan for (R78) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with current regulations. " The facility policy titled, Urinary Tract Infection (UTI) Prevention and	

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F 441	Continued From page 33 contaminated and the antibiotic was continued. R20 developed 2 urinary tract infections. In each case only one symptom was identified. In each case two different organisms were identified for each infection. R8 developed 2 urinary tract infections. Only one or two symptoms were identified. One infection did not have an identified micro-organism and the other infection identified two micro-organisms responsible for the infection. R78 developed 2 urinary tract infections. R78 had a indwelling catheter. Two symptoms were identified for each infection, but only one infection identified the micro-organisms responsible (2 micro organisms). The infection control nurse documentation was reviewed. The documentation did not note that the number of identified symptoms present did not correspond to the policy (3 symptoms for non-catheter and 2 symptoms if catheter). The analysis provided for the quality committee did not identify trends of recurrent UTIs of or recurrent micro-organisms. The facility policy entitled Urinary Tract Infection (UTI) Prevention and Management dated 2/3/09 read, : 1. Do not treat asymptomatic UTI. Indications to treat UTI without a catheter should have 3 of the following::a) fever, b) increased burning, pain on urination, frequency, or urgency, c)new flank pain d)change in character of urine, e) worsening of mental or functional status. 2. Do not treat asymptomatic UTI. Indications to treat a UTI with a catheter must have 2 of the	F 441	Management dated 2/3/2009 has been modified as of 12/19/2014. New policy title, Urinary Tract Infection (UTI) Identification, Treatment, Prevention and Management will be reviewed for approval at the QA meeting on 1/13/2015. Implementation or further modification to be made following that meeting. " The infection control nurse will track individual resident infections and any resident identified as having 2 or more UTIs in a 6 month time frame will then be reviewed at the QA meeting with the team and the medical director to identify any other needed action or intervention. " A process for tracking symptoms and antibiotic therapy used for treatment of UTIs will be added to the monthly data collection completed by the Infection Control Nurse. " A random audit of care plan topics, goals and interventions will be completed at the discretion of the DON to ensure individualization is in place. " The 13 page document titled, Guideline for the Diagnosis and Management of Urinary Tract Infections in Long Term Care from TOP (Toward Optimized Practice Program). This document includes the Clinical Pathway. Pieces of this document will be used in providing training to staff. " Administrator attended resident council on 12/2/2014 reviewed citations with residents and encouraged residents to notify Administrator of any concerns that staff do not address. " Education was provided to staff at an in-service training on 12/11/2014. All staff	

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F 441	Continued From page 34 following: a) fever or chills b) new flank pain, c) change in character of urine." 22 other residents also had developed a single episode of UTI during the time period of April through October 2014. The infection control nurse documentation was reviewed. The reports lacked the 2 or 3 symptoms identified in accordance with the policy and the infection control nurse documentation lacked identification of the micro-organism. The analysis of data provided by the director of nursing did not indicate a repetition of micro-organisms between residents with infections in a given month. *April 2014 3 UTIs identified by the facility-one resident was not identified above. R19 had 3 symptoms listed, but no culture results. The infection control nurse had not documented on this resident. *May 2014. 7 UTIs identified by the facility-5 not identified above. R67 had documentation that indicated only one symptoms (behavior change). The micro-organism was identified. R25 had one symptom of elevated temperature and also an elevated white count. The culture results were noted. R38 had only one symptom documented as an indicator of a UTI, no micro-organism was reported. R5 had one symptom documented as an indicator of a UTI and no micro-organism was reported. R44 had two symptoms documented as an indicator of a UTI and 2 micro-organisms were identified. Review of the documentation provided indicated Proteus mirabilis, Klebsiella Pneumoniae, and E-coli were micro-organisms identified in 4 of the infections. *June 2014 6 UTIs were identified by the facility-2 not listed as residents with multiple	F 441	will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility of the RN unit managers and the licensed staff as well as the Infection Control Nurse with overall compliance being the responsibility of the Director of Nursing Services.	

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F 441	Continued From page 35 infections. R59 was admitted to the hospital with acute lower UTI. No information related to symptoms or culture results was identified on the hospital discharge summary or infection documentation. R75 had a catheter and had one symptom documented as an indicator of a UTI and also a urinalysis. Two micro-organisms were identified. Review of the documentation of the 6 UTIs identified for the month three of the infections did not have micro-organisms listed by the infection control nurse. *July 2014 4 UTIs were identified by the facility-3 not listed as residents with multiple UTIs. R12 had a catheter and had one symptom identified as an indicator or a UTI. No micro-organism was identified by the infection control nurse. R64 was admitted to the hospital with a diagnosis of UTI. The infection control nurse did not document symptoms or micro-organisms. R35 had two symptoms identified indicating a UTI and a micro-organism was identified. Review of the documentation provided indicated that all 4 infections lacked documented symptoms as identified by the policy and two lacked documented micro-organism. *August 2014 6 UTIs were identified for the month-3 were not identified as residents with recurrent UTIs. R31 had two symptoms indicating a UTI and a micro-organism listed. R56 had two symptoms and two micro-organisms identified. R55 had one symptoms listed and no micro-organism identified. Review of the infection control nurse documentation indicated only 4 of the 6 infections had identified micro-organisms and three of the 4 had the same organisms-E-Coli, Klebsiella Pneumoniae, and Proteus Mirabilis. Only one of the 6 residents had the symptoms identified in accordance with the	F 441		

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F 441	Continued From page 36	F 441		

facility policy.
*September 2014 4 UTIs identified by the facility- three residents identified as having multiple/recurrent UTIs and are listed above. R6 had no symptoms indicating a UTI listed but had micro-organisms identified. Review of the infection control documentation indicated one of the reports had indicated symptoms identifying a potential UTI and only two had identified micro-organisms.
*October 2014 3 UTIs were identified- 2 were not identified as having recurrent UTIs. R87 had one symptoms identified indicating a UTI and a micro-organism listed. R999 had one symptom identified indicating a UTI and micro-organism identified. Review of the infection control documentation indicated two of the 3 UTIs had the same micro-organism identified-E-Coli and all lacked identifying symptoms according to the policy.

A line listing of infections was provide on 11/17/14 at 7:45 p.m. by the director of nursing. She indicated this was the information provided to the quality assurance (QA) committee meeting. The line listing did not include the resident name, culture results, interventions or resolution. During an interview on 11/29/14 the director of nursing indicated infections were tracked on a map monthly to identify patterns. During an interview on 11/21/14 at 2:00 p.m. the administrator stated the infection rate and information was part of the QA committee process.

During an interview on 11/25/14 at 10:44 a.m. the director of nursing (DON) indicated she felt the urinary tract infections were being analyzed and pattern. It had been determined that the four residents with catheters would chronically have

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F 441	Continued From page 37 bacteria and that the medical director had decided that these residents would no longer have urine cultures but rather white blood cell counts to determine a possible infection. The director of nursing indicated only 2 symptoms were necessary to determine a potential UTI and collect a urine culture as directed in the standing order. The symptoms would be determined by asking the resident, notifying changes in behavior, or past history. During the interview the director of nursing indicated if a resident had a potential UTI, staff were to encourage fluids, provide perineal care, offer reminders, and good hand washing. When reviewing the infection reports with the director of nursing on 11/25/14 at 2:30 p.m. she stated she realized that residents with catheters were having recurrent UTIs, but did not realize that other residents were also. Lack of monitoring antibiotic effectiveness not tracked: The facility's policy entitled Infection Control dated 12/12/13 indicated staff were to have appropriate in-service training on managing infections in residents. The policy also read, "Through ongoing monitoring this facility will take appropriate actions per State and Federal Guidelines to investigate, prevent, control and report disease and infection." The policy identified Tracking and trending Infections: as a) investigation, b)data collection as to type of infection, location, resident and facility or community acquired, c) calculate the data and compare rates over time to identify pattern, clusters, trends and opportunities for improvement, d) monitor for recurrent infections in residents. During the interview on 11/25/14 at 10:44 a.m. the director of nursing stated the facility had a nurse	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 dedicated to infection control and quality assurance. DON indicated it with the infection control nurse's responsibility to monitor and implement infection control program. The DON reviews the reports and takes this information to qualify committee. DON indicated the medical director was very involved with the infection control program and monitoring of infections. During an interview on 11/25/14 at 10:52 a.m. the director of nursing indicated the facility would monitor micro-organisms, but not track antibiotics. She added on resident specific logs, infections, not antibiotic use was tracked. The administrator was interviewed on 11/21/14 at 2:00 p.m. She indicated the medical director would be present at the quality assurance committee meeting and had input into the meeting. The infection control list of infections and re-occurring infections would be discussed and reviewed by the medical director. The administrator stated that she had not recognized the large number of UTIs. The infection control nurse tracks the UTIs and infections. The infection control nurse would be responsible to educate staff on perineal care. The administrator stated she had no concerns related to the number of UTIs at present.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5102023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE** **WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sauer Health Care was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 12/26/2014

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sauer Health Care is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type III(211) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type III(211)construction. In 1976, 1982, and 1995 additions were added to the North Wings that were determined to be of Type III (211) construction. Because the original building and the 4 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III(211). The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification, and single station smoke alarms in the residents room.	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 The facility has a capacity of 71 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out 62 residents. Findings include: On facility tour between 9:30 AM and 1:00 PM on 11/19/2014, observation revealed, that the following was found:	K 029	In response to the above stated citation Sauer Health Care has taken the following action: " All open penetrations have been sealed with the appropriate material. " The doors have been adjusted or repaired to insure a positive latch. " Administrator attended resident council on 12/2/2014 and reviewed citations including this one. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015.	1/4/15

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K 029	Continued From page 3 1. Basement - south storage room (over 50 sq ft), open penetration around conduit east wall 2. Basement - soil linen room door, will not shut and latch 3. Basement - storage (over 50 sq ft) by elevator will not shut and latch 4. 1st floor - east wing custodian room open penetration where pipe was removed These deficient practices were confirmed by the Director of Maintenance (DM) at the time of discovery.	K 029	" Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility the Maintenance Department Manager.	
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 19.3.1.1, 8.2.5.2. This could effect 40 out of 62 residents. Findings include: On facility tour between 9:30 AM and 1:00 PM on 11/19/2014, observation revealed that the following was found in the Basement - front	K 033	In response to the above stated citation Sauer Health Care has taken the following action: " The doors have been adjusted or repaired to insure a positive latch. " All open penetrations have been sealed with the appropriate material. " Administrator attended resident council on 12/2/2014 and reviewed citations including this one. " Education was provided to staff at an in-service training on 12/11/2014. All staff	1/4/15

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K 033	Continued From page 4 stairwell: 1. Doors to classroom and beauty shop will not shut and latch, 2. Penetration around sprinkler line These deficient practices were confirmed by the Facility Maintenance Director (DM) at the time of discovery.	K 033	will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility the Maintenance Department Manager.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 20 out of 62 residents. Findings include: On facility tour between 9:30 AM and 1:00 PM on 11/19/2014, observation revealed that the basement floor - spare sprinkler head box - does not contain (2) spare sprinkler heads of each type.	K 062	In response to the above stated citation Sauer Health Care has taken the following action: " An inventory of building sprinkler heads was made and any missing sprinkler heads were ordered to insure the proper amounts of spare heads are in the spare sprinkler head box. " Administrator attended resident council on 12/2/2014 and reviewed citations including this one. " Education was provided to staff at an in-service training on 12/11/2014. All staff will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective action	1/4/15

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K 062	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director (DM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	and ongoing prevention to be reviewed at QA meeting on 1/13/2015. Compliance for adherence to this plan will be the responsibility the Maintenance Department Manager.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
December 15, 2014

Ms. Sara Blair, Administrator
Sauer Health Care
1635 West Service Drive
Winona, Minnesota 55987

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5102024

Dear Ms. Blair:

The above facility was surveyed on November 17, 2014 through November 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me or Kathryn Serie, Unit Supervisor Minnesota Department of Health, Kathryn.serie@state.mn.us Office: (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	11/25/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates.... surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to identify recurrent urinary tract infections (UTI), monitor and tract symptoms, monitor and analyze data to minimize the risk of recurrent UTIs and the facility failed to provide staff education for 5 of 5 residents (R51, R14, R20, R8 and R78) with recurrent urinary infections and for these 17 additional residents ((R19, R67, R25, R38, R5, R44, R59, R75, R12, R64, R35, R31, R56, R55, R6, R87 & R999) identified by the facility on the infection logs between April and October 2014.	2 285		

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2 285	Continued From page 3	2 285		

Findings include:

R51 developed 5 urinary tract infections between April 24, 2014 and September 12, 2014. R51 had an indwelling catheter. Documentation completed by the infection control nurse indicated R51 would display one symptoms indicating a possible UTI (behaviors, confusion, agitation, blood pressure changes). On two occasions 2 symptoms were identified. The micro-organism was identified for three of the infections and each culture identified the same micro-organism. Two different antibiotics were identified used for the same micro-organism.

R14 developed 4 urinary tract infections between June 2014 and September 2014. Documentation completed by the infection control nurse indicated R14 had displayed only falls for 2 of the infections. The June infection documentation indicated 3 symptoms and the other infection documentation indicated 2 symptoms had been identified. Two different micro-organisms had been identified for the four infections. In June the infection control nurse noted the culture results were probably contaminated and the antibiotic was continued.

R20 developed 2 urinary tract infections. In each case only one symptom was identified. In each case two different organisms were identified for each infection.

R8 developed 2 urinary tract infections. Only one or two symptoms were identified. One infection did not have an identified micro-organism and the other infection identified two micro-organisms responsible for the infection.

R78 developed 2 urinary tract infections. R78

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2 285	Continued From page 4	2 285		

Continued From page 4

had a indwelling catheter. Two symptoms were identified for each infection, but only one infection identified the micro-organisms responsible (2 micro organisms).

The infection control nurse documentation was reviewed. The documentation did not note that the number of identified symptoms present did not correspond to the policy (3 symptoms for non-catheter and 2 symptoms if catheter). The analysis provided for the quality committee did not identify trends of recurrent UTIs of or recurrent micro-organisms.

The facility policy entitled Urinary Tract Infection (UTI) Prevention and Management dated 2/3/09 read, :
1. Do not treat asymptomatic UTI. Indications to treat UTI without a catheter should have 3 of the following::a) fever, b) increased burning, pain on urination, frequency, or urgency, c)new flank pain d)change in character of urine, e) worsening of mental or functional status.
2. Do not treat asymptomatic UTI. Indications to treat a UTI with a catheter must have 2 of the following: a) fever or chills b) new flank pain, c) change in character of urine."

22 other residents also had developed a single episode of UTI during the time period of April through October 2014. The infection control nurse documentation was reviewed. The reports lacked the 2 or 3 symptoms identified in accordance with the policy and the infection control nurse documentation lacked identification of the micro-organism. The analysis of data provided by the director of nursing did not indicate a repetition of micro-organisms between residents with infections in a given month.

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2 285	Continued From page 5	2 285		

*April 2014 3 UTIs identified by the facility-one resident was not identified above. R19 had 3 symptoms listed, but no culture results. The infection control nurse had not documented on this resident.

*May 2014. 7 UTIs identified by the facility-5 not identified above. R67 had documentation that indicated only one symptoms (behavior change). The micro-organism was identified. R25 had one symptom of elevated temperature and also an elevated white count. The culture results were noted. R38 had only one symptom documented as an indicator of a UTI, no micro-organism was reported. R5 had one symptom documented as an indicator of a UTI and no micro-organism was reported. R44 had two symptoms documented as an indicator of a UTI and 2 micro-organisms were identified.

Review of the documentation provided indicated Proteus mirabilis, Klebsiella Pneumoniae, and E-coli were micro-organisms identified in 4 of the infections.

*June 2014 6 UTIs were identified by the facility-2 not listed as residents with multiple infections. R59 was admitted to the hospital with acute lower UTI. No information related to symptoms or culture results was identified on the hospital discharge summary or infection documentation. R75 had a catheter and had one symptom documented as an indicator of a UTI and also a urinalysis. Two micro-organisms were identified.

Review of the documentation of the 6 UTIs identified for the month three of the infections did not have micro-organisms listed by the infection control nurse.

*July 2014 4 UTIs were identified by the facility-3 not listed as residents with multiple UTIs. R12 had a catheter and had one symptom identified as an indicator or a UTI. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 285	Continued From page 6	2 285		

micro-organism was identified by the infection control nurse. R64 was admitted to the hospital with a diagnosis of UTI. The infection control nurse did not document symptoms or micro-organisms. R35 had two symptoms identified indicating a UTI and a micro-organism was identified. Review of the documentation provided indicated that all 4 infections lacked documented symptoms as identified by the policy and two lacked documented micro-organism.
*August 2014 6 UTIs were identified for the month-3 were not identified as residents with recurrent UTIs. R31 had two symptoms indicating a UTI and a micro-organism listed. R56 had two symptoms and two micro-organisms identified. R55 had one symptoms listed and no micro-organism identified. Review of the infection control nurse documentation indicated only 4 of the 6 infections had identified micro-organisms and three of the 4 had the same organisms-E-Coli, Klebsiella Pneumoniae, and Proteus Mirabilis. Only one of the 6 residents had the symptoms identified in accordance with the facility policy.
*September 2014 4 UTIs identified by the facility- three residents identified as having multiple/recurrent UTIs and are listed above. R6 had no symptoms indicating a UTI listed but had micro-organisms identified. Review of the infection control documentation indicated one of the reports had indicated symptoms identifying a potential UTI and only two had identified micro-organisms.
*October 2014 3 UTIs were identified- 2 were not identified as having recurrent UTIs. R87 had one symptoms identified indicating a UTI and a micro-organism listed. R999 had one symptom identified indicating a UTI and micro-organism identified. Review of the infection control documentation indicated two of the 3 UTIs had

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	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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2 285	Continued From page 7	2 285		

the same micro-organism identified-E-Coli and all lacked identifying symptoms according to the policy.

A line listing of infections was provide on 11/17/14 at 7:45 p.m. by the director of nursing. She indicated this was the information provided to the quality assurance (QA) committee meeting. The line listing did not include the resident name, culture results, interventions or resolution. During an interview on 11/29/14 the director of nursing indicated infections were tracked on a map monthly to identify patterns. During an interview on 11/21/14 at 2:00 p.m. the administrator stated the infection rate and information was part of the QA committee process.

During an interview on 11/25/14 at 10:44 a.m. the director of nursing (DON) indicated she felt the urinary tract infections were being analyzed and pattern. It had been determined that the four residents with catheters would chronically have bacteria and that the medical director had decided that these residents would no longer have urine cultures but rather white blood cell counts to determine a possible infection. The director of nursing indicated only 2 symptoms were necessary to determine a potential UTI and collect a urine culture as directed in the standing order. The symptoms would be determined by asking the resident, notifying changes in behavior, or past history. During the interview the director of nursing indicated if a resident had a potential UTI, staff were to encourage fluids, provide perineal care, offer reminders, and good hand washing.
When reviewing the infection reports with the director of nursing on 11/25/14 at 2:30 p.m. she stated she realized that residents with catheters were having recurrent UTIs, but did not realize

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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2 285	Continued From page 8	2 285		

that other residents were also.
Lack of monitoring antibiotic effectiveness not tracked:
The facility's policy entitled Infection Control dated 12/12/13 indicated staff were to have appropriate in-service training on managing infections in residents. The policy also read, "Through ongoing monitoring this facility will take appropriate actions per State and Federal Guidelines to investigate, prevent, control and report disease and infection." The policy identified Tracking and trending Infections: as a) investigation, b)data collection as to type of infection, location, resident and facility or community acquired, c) calculate the data and compare rates over time to identify pattern, clusters, trends and opportunities for improvement, d) monitor for recurrent infections in residents.
During the interview on 11/25/14 at 10:44 a.m. the director of nursing stated the facility had a nurse dedicated to infection control and quality assurance. DON indicated it with the infection control nurse's responsibility to monitor and implement infection control program. The DON reviews the reports and takes this information to qualify committee. DON indicated the medical director was very involved with the infection control program and monitoring of infections.
During an interview on 11/25/14 at 10:52 a.m. the director of nursing indicated the facility would monitor micro-organisms, but not track antibiotics. She added on resident specific logs, infections, not antibiotic use was tracked.

The administrator was interviewed on 11/21/14 at 2:00 p.m. She indicated the medical director would be present at the quality assurance committee meeting and had input into the meeting. The infection control list of infections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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2 285	Continued From page 9 and re-occurring infections would be discussed and reviewed by the medical director. The administrator stated that she had not recognized the large number of UTIs. The infection control nurse tracks the UTIs and infections. The infection control nurse would be responsible to educate staff on perineal care. The administrator stated she had no concerns related to the number of UTIs at present. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise policies and procedures for evaluating need for staff education related to infection control issues.. The Director of Nursing or designee could provide education programs and could monitor staff performance. TIME PERIOD FOR CORRECTIONS: Fourteen (14) days.	2 285		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must	2 540		

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	00705	A. BUILDING: ___ B. WING ___	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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2 540	Continued From page 10	2 540		

include at least the following information:
A. medically defined conditions and prior medical history;
B. medical status measurement;
C. physical and mental functional status;
D. sensory and physical impairments;
E. nutritional status and requirements;
F. special treatments or procedures;
G. mental and psychosocial status;
H. discharge potential;
I. dental condition;
J. activities potential;
K. rehabilitation potential;
L. cognitive status;
M. drug therapy; and
N. resident preferences.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to complete a comprehensive sleep assessment to determine interventions to control insomnia for 1 of 1 resident (R91) admitted to the facility with a diagnosis of insomnia and receiving a sleep medication.

Findings include:

R91 was not comprehensively assessed for insomnia according to the Minimum Data Set requirements for all residents admitted to the facility.

R91 was admitted to the facility 11/3/14 and had diagnoses as listed on the physician orders as acute kidney failure, diabetes, anxiety, depression, and insomnia. The CAA (care area assessment) text note dated 11/14/14 indicated R91 had a BIMS (brief interview for mental status) of 8 out of 15 or moderately impaired, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ________ B. WING ________	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 11 PHQ-9 score of 1 indicating minimal depression and included a diagnosis of progressive dementia. R91 had physician orders dated 11/3/14 for diazepam (Valium) at bedtime for anxiety, and Trazodone (antidepressant used out of class as a sleeping aide) at bedtime for insomnia The CAA note text dated 11/14/14 identified these medications, but did not include an assessment for sleep or interventions to help R91 attain sleep without medication. The CAA list of factors that could cause or exacerbate the behaviors did not identify sleep disturbances. The facility's Comprehensive Nursing Assessment for admission effect 11/3/14 did not identify a sleep disturbance or behavior/mood symptoms/behaviors or interventions for managing the insomnia or behavioral symptoms. Registered nurse (RN)-B was interviewed on 11/21/14 at 10:50 a.m. RN-B stated it was not necessary to look at the medications for anxiety, insomnia and depression for 3 months according to regulations. RN-B noted the facility monitored R91's sleep pattern. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all nurses responsible for assessments of residents the need to full complete the Minimum Data Set. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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2 555	Continued From page 12	2 555		

Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to develop a plan of care related to monitoring for signs and symptoms related to the resident's medical diagnosis which includes medication use, diet and fluid restriction for 1 of 5 residents (R39) reviewed for unnecessary medications.

Findings include:

R39 was observed on 11/18/14 at 10:55 a.m. sitting in a wheelchair with feet on floor. R39's wife stated R39 had been in the facility for two months because she was unable to care for him at home.

R39 was readmitted to the facility on 10/24/14 and had diagnoses listed on the physician orders dated 10/24/14 as chronic kidney disease, gout, coronary atherosclerosis, paralysis agitans (Parkinson's) , hypertonicity of bladder, hypertrophy prostate, long-term use of

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	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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2 555	Continued From page 13	2 555		

anticoagulants, hypertension, depression, dementia.

R39's physician orders included: fluid restriction, low sodium/low cholesterol diet. Medications including aspirin and Coumadin, Detrol for hypertonicity of bladder, Flomax, for hypertrophy prostate, torsemide and Zestril diuretics for congestive heart failure.

R39's care plan printed 11/21/14 was reviewed. The care plan did not include problems or interventions to direct staff related to the diet and fluid restrictions, gout, the use of medications for bladder and prostate issues or diuretic use except to identify incontinence. The care plan did not include the use of Coumadin and aspirin and risk for bleeding in which the nursing aides need to be alerted to in case of bleeding or other symptoms that need immediate interventions.

The facility's policy dated 3/3/14 entitled Care Plans-Comprehensive noted an "individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, nursing, mental and psychological needs is developed for each resident."

The director of nursing (DON) was interviewed on 11/25/14 at 9:57 a.m. and verified the care plan did not include possible side effects related to medications for anticoagulants, high blood pressure, depression, special diet and fluid restrictions.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Care Plans are developed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 14 for appropriate care of the resident with multiple medical issues. . The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for personal hygiene for nail care for 1 of 3 residents (R31) reviewed for activities of daily living. Findings include: R31 had been admitted on 5/15/14. R31's quarterly Minimum Data Set (MDS) dated 10/30/14, identified but not limited to diagnoses of dementia and required extensive assist of one person for personal hygiene. During observation on 11/18/14, at 10:17 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

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2 565	Continued From page 15 debris observed underneath on four of the five fingernails. On 1/20/14 at 10:31 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown debris observed underneath the same four fingernails. R31's care plan dated 6/24/14, identified problem: self-care deficit related to dementia with interventions of but not limited to totally dependent on one staff for bathing, needs extensive assist of one staff for personal hygiene. During an observation on 11/21/14 at 10:27 a.m., nursing assistant (NA)-A verified the dirty fingernails on R31's right hand. NA-A stated staff clean residents fingernails on their bath days during bathing and as needed. NA-A stated she would take care of cleaning R31's fingernails today. During an observation on 11/21/14 at 10:28 a.m., registered nurse (RN)-B verified the dirty fingernails on R31's right hand and stated they needed to be cleaned. RN-B stated staff was to clean R31's fingernails on her bath day and as needed. RN-B stated R31 had her bath day on Wednesday in the morning. During an interview on 11/21/14 at 10:44 a.m. the director of nursing stated she expected all resident fingernails to be cleaned on their bath day and stated staff should clean resident fingernails as needed as a part of their daily cares. During an interview on 11/21/14 at 11:30 a.m., the DON stated she considered ensuring clean fingernails would be included in providing extensive assist of one for personal hygiene and	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 16 verified the care plan had not been followed for R31. A policy was requested for following the comprehensive care plan at this time and one was not provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive care according to the plan of care; educate all relevant staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include personal hygiene of shaving for 1 of 1	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 17	2 570		

Continued From page 17

residents (R65) with long facial hair.

Findings include:

R65 was observed on 11/18/14 at 9:00 a.m. and 11/25/14 at 9:40 a.m. with long facial hair on her chin and neck.

The annual Minimum Data Set dated 10/21/14 indicated R65 required extensive assistance of one staff with personal hygiene. The care plan dated 10/21/14 indicated R65 was able to perform some of her own personal hygiene following staff assistance with set up. The care plan did not indicate if R65 needed assistance with shaving or obtaining a razor.

The nursing assistant flow sheet indicated R65 required assist of one with activities of daily living. The flow sheet did not indicate the need for shaving of facial hair.

The facility policy dated 3/3/14 entitled Care Plans-comprehensive read, "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans."

The director of nursing (DON) was interviewed on 11/25/13 at 10:03 a.m. DON stated care plan and nursing assistant flow sheet should address the issue of shaving.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Care Plans are revised as needed to provide for appropriate care of the resident with multiple medical issues. .

The Director of Nursing or designee could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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2 570	Continued From page 18 educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to include facial hair removed per resident request for 1 of 1 resident (R65) observed with facial hair. Findings include: R65 was observed on 11/18/14 at 9:00 a.m. with long facial hair on her chin and neck. R65 stated she would generally have them shaved, but that the razor was dull. The facial hair was gray and about an inch in length. On 11/25/14 at 9:40 a.m. R65 was observed to have facial hair on the chin and neck. The resident commented "Oh do I have it again" in regards to the question about the long chin hair. R65 stated staff use their own razor and she would forget to tell them to shave her. R65 stated it bothered her if the facial hair was long.	2 850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 850	Continued From page 19	2 850		

The annual Minimum Data Set dated 10/21/14 indicated R65 required extensive assistance of one staff with personal hygiene. The care plan dated 10/21/14 indicated R65 was able to perform some of her own personal hygiene following staff assistance with set up. The nursing assistant flow sheet indicated R65 required assist of one with activities of daily living. Neither the care plan or flow sheet did not indicate the need for shaving of facial hair.

The director of nursing (DON) was interviewed on 11/25/13 at 10:03 a.m. and stated the nursing assistants were to have a resident shaved as part of the morning cares.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could in-service all staff on performing activities of daily living including shaving for residents. The director of nursing or designee could schedule audits to monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 860 — MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet — 2 860

Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:
E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.

This MN Requirement is not met as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 20	2 860		

by:
Based on observation, interview and document review the facility failed to ensure clean nails for 1 of 3 residents (R31) reviewed for activities of daily living.

Findings include:

R31 had been admitted on 5/15/14. R31's quarterly Minimum Data Set (MDS) dated 10/30/14, identified but not limited to diagnoses of dementia, depression and required extensive assist of one person for personal hygiene.

During observation on 11/18/14, at 10:17 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown debris observed underneath four fingernails.

During an observation on 11/20/14 at 10:31 a.m., R31 had been in room sitting in wheelchair. R31's fingernails on her right hand had dark brown debris observed underneath the same four fingernails.

R31's care plan dated 6/24/14, identified problem: self-care deficit related to dementia with interventions of but not limited to totally dependent on one staff for bathing, needs extensive assist of one staff for personal hygiene.

During an observation on 11/21/14 at 10:27 a.m., nursing assistant (NA)-A verified the dirty fingernails on R31's right hand. NA-A stated staff clean residents fingernails on their bath days during bathing and as needed. NA-A stated she would take care of cleaning R31's fingernails today.

During an observation on 11/21/14 at 10:28 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 21	2 860		

registered nurse (RN)-B verified the dirty fingernails on R31's right hand and stated they needed to be cleaned. RN-B stated staff was to clean R31's fingernails on her bath day and as needed. RN-B stated R31 had her bath day on Wednesday in the morning.

During an interview on 11/21/14 at 10:44 a.m. the director of nursing stated she expected all resident fingernails to be cleaned on their bath day and stated staff should clean resident fingernails as needed as a part of their daily cares.

The Nail Care of (Finger and Toe) policy dated 2/3/09 read, "Resident's unable to care for finger and toe nails will be assisted as needed."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule audits to monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 910 — MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence — 2 910

Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who enters a nursing home without an indwelling catheter is not catheterized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 22	2 910		

unless the resident's clinical condition indicates that catheterization was necessary; and
B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to comprehensively assess urinary tract infection (UTI) risk and develop an individualized plan of care for 5 of 5 residents (R51,R14, R78, R8, R20) with a history of recurrent urinary tract infections.

Findings include:

R51 developed urinary tract infections on 4/24/14, 5/13/14, 6/27/14, 8/29/14, and 9/12/14. On 9/13/14 R51 was diagnosed with Septicemia due to gram negative organism and urinary tract infection resulting in hospitalization and intravenous antibiotics. Review of the hospital history and physical (H & P) dated 9/13/14 R51 had been admitted to the hospital related to septic shock with E coli bacteremia from a complicated UTI in January 2014. The H & P (history and physical) indicated R51 had also been seen in the emergency room on 8/26/14 and diagnosed with a UTI.

The hospital history and physical dated 9/13/14 was reviewed. R52 was admitted to the hospital related to septic shock secondary to infection and stated R51 was displaying signs of end organ damage from the shock. The H & P indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 23	2 910		

UTI was a recurrent problem. The H & P also indicated acute kidney injury related to the sepsis, hypotension, and need for aggressive hydration.

The facility's comprehensive nursing assessment for R51 dated 11/12/14 was provided and reviewed. The assessment noted a bowel and bladder screener indicated R51 was incontinent of bladder and stool, had terminal end stage medical issues including prostate cancer, had a catheter and a history of frequent UTIs, The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors related to catheter use, contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment.

R51's plan of care printed 11/25/14 included a focus of " was hospitalized with urosepsis with bacteremia, history of MRSA (methylene resistant staphylococcus aureus) in urine that the nurse practitioner on 3/25/14 noted R51 was likely colonized, and had an in dwelling catheter related to prostate cancer. The interventions directed staff to change the catheter and observed for signs of a UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R14 developed urinary tract infections on 6/9/14, 7/17/14, 8/14/14, 9/12/14 and lacked interventions to prevent more UTIs from developing.

The facility's comprehensive nursing assessment dated 9/23/14 noted infrequent incontinence of bladder, predisposing factors for incontinence and a bowel ostomy. The assessment lacked identification of risk factors for developing urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 24	2 910		

tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment.

R14's care plan printed 11/25/14 indicated R14 was frequently incontinent of urine, but lacked interventions related to approaches to help minimize the risk of recurrent UTIs.

R78 developed urinary tract infections on 5/2/14, 6/16/14. On 6/12/14 R78 was also diagnosed with C-Diff (Clostridium difficile (klos-TRID-e-um dif-uh-SEEL), often called C. difficile or C. diff) infection according to the infection control log.

The facility's comprehensive nursing assessment dated 9/17/14 indicated R78 was occasionally incontinent, had a catheter that would occasionally leak. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors related to catheter use, contributing factors or co-morbidity related to medical conditions, cognitive function, medications, or assessments of factors that could lead to septicemia and bacteremia.

R78 had a care plan printed 11/25/14 that indicated a diagnosis of neurogenic bladder and chronic indwelling catheter. The interventions directed staff to change the catheter and observe for signs of a UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R8 developed urinary tract infections on 6/15/14, 10/20/14 and lacked interventions to reduce UTIs.

The comprehensive nursing assessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 25	2 910		

9/5/14 indicated R8 was occasionally incontinent of bowel and bladder and had no untreatable predisposing incontinence risk factors. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications.

The plan of care printed 11/25/14 indicated a longstanding history of urinary frequency and urgency and directed staff to monitor for signs of urinary tract infections. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

R20 developed urinary tract infections on 4/29/24, 8/5/14 and lacked interventions to prevent recurrence of UTIs.

The comprehensive nursing assessment dated 9/12/14 indicated R20 was occasionally incontinent, was independent with toileting and had no predisposing factors for incontinence. The assessment lacked identification of risk factors for developing urinary tract infections, such as contributing factors or co-morbidity related to medical conditions, cognitive function, medications, physical function or environment.

The plan of care printed 11/25/14 had a focus of longstanding diagnosis of stress incontinence and interventions to identify signs of UTI. The interventions did not provide staff with approaches to help minimize the risk of recurrent UTIs.

The director of nursing was interviewed on 11/25/14 at 2:30 p.m. She indicated the comprehensive nursing assessments and care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 26 plans were completed on each resident. She stated no other assessments related to urinary tract infection risks or individualized care plans to minimize the risk of recurrent infections had been completed. The facility policy entitled Urinary Tract Infection (UTI) Prevention and Management dated 2/3/09 did not direct nursing staff to assess a resident for the risk of developing urinary tract infections and did not direct the development of an individualized care plan to assist staff with approaches to him minimize the risk of recurrent urinary tract infections. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all employees responsible for preventing urinary tract infections on the need to assess and develop interventions to prevent urinary tract infections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerator shelving in 2 of 2 walk in coolers was maintained	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 27	21015		

Continued From page 27

in a clean and sanitary manner. This had the potential to affect all 62 residents in the facility that had been provided food prepared and distributed from the facility kitchen.

Finding Include:

During the initial kitchen tour on 11/17/14, at 6:10 p.m., with cook (C)-A the walk-in dairy cooler was observed to have 6 out of 18 shelves with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. The second walk-in cooler was observed to have 15 out of 23 shelves observed with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black.

On 11/17/14 at 6:17 p.m. C-A verified the identified shelves in the walk-in coolers had areas with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. Cook-A verified the cleaning schedule indicated the floors of the walk-in coolers were to be cleaned on Wednesdays and verified the cleaning schedule did not include cleaning the shelving in the walk-in coolers.

During a kitchen observation on 11/17/14, at 8:50 p.m., with another surveyor and the certified dietary manager (CDM), the CDM verified the six identified shelves in the walk-in dairy cooler and the fifteen identified shelves in the second walk-in cooler had areas with spots, hanging clumps, and fuzzy areas of debris in varying colors of gray, green and black. The CDM stated the areas of concern on the identified shelving in the walk-in coolers were mold. The CDM verified the shelving in the walk-in coolers was not listed on the daily Cleaning Schedule in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 28 During an interview on 11/18/14, at 7:45 a.m., the administrator stated the refrigerators have been cleaned. The administrator stated she reviewed the policy and verified the policy/procedure does not specifically list cleaning of the shelves in the walk-in coolers. During a kitchen observation and interview with the CDM on 11/18/14, at 8:47 a.m., the dairy walk-in cooler was observed to have been cleaned and had eighteen shelves in the cooler. The second walk-in cooler was observed to have been cleaned and had only 16 out of the 23 shelves initially observed in the cooler. The CDM stated some of the shelving from the second walk-in cooler was going to be replaced because of its condition. The CDM stated Asbesbegon (an abatement contractor) company was contacted last night by maintenance for a recommendation on how to clean the walk-in coolers because of the mold concern. The CDM stated the shelving in both walk-in coolers was power washed, all the shelves, the walls and flooring was cleaned with Sanotracin RTU, a mold killing chemical recommended by Asbesbegon. The CDM stated she completed audits of the kitchen areas but apparently not well enough because the mold on the shelves in the walk-in coolers was missed. The CDM stated she had a staff meeting this morning and discussed the need for staff to be aware of cleanliness in the kitchen. The CDM stated, "I don't know what to say. I am upset this happened. There is nothing I can say. It should not have happened." The CDM stated all kitchen staff will be re-educated on maintaining a clean and sanitary kitchen and the daily cleaning schedule will be revised to include the shelving in the walk-in coolers. During an interview on 11/18/14 at 9:34 a.m., the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 29	21015		

director of nursing (DON) stated she reviewed the documentation of tracking and trending of staff illness in the kitchen and there was no correlation between staff illness that can be related to the mold found in the kitchen walk-in coolers.

The General Sanitation of Kitchen policy dated 12-7-11 read, "The Dietary Services staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.
Procedure:
1. Cleaning and sanitation tasks for the kitchen will be recorded.
2. Tasks will be assigned to be the responsibility of specific positions per cleaning schedule.
3. Tasks will be addressed as to frequency of cleaning.
4. A cleaning schedule will be posted and employees will initial and date tasks when completed ..."

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) certified dietary manager (CDM) and/or designee could develop/review/ revise policies and procedures and provide education for staff related to sanitation and cleaning of the food refrigerators and food storage areas. The DON, CDM or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ____ B. WING ____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 30	21390		

Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:

A. surveillance based on systematic data collection to identify nosocomial infections in residents;

B. a system for detection, investigation, and control of outbreaks of infectious diseases;

C. isolation and precautions systems to reduce risk of transmission of infectious agents;

D. in-service education in infection prevention and control;

E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;

F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;

G. a system for reviewing antibiotic use;

H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and

I. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to identify recurrent urinary tract infections (UTI), monitor and tract symptoms, monitor and analyze data to minimize the risk of recurrent UTIs and the facility failed to provide staff education for 5 of 5 residents (R51, R14, R20, R8 and R78) with recurrent urinary infections and for these 17 additional residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 31	21390		

((R19, R67, R25, R38, R5, R44, R59, R75, R12, R64, R31, R56, R55, R6, R87, R999 and R87) identified by the facility on the infection logs between April and October 2014.

Findings include:

R51 developed 5 urinary tract infections between April 24, 2014 and September 12, 2014. R51 had an indwelling catheter. Documentation completed by the infection control nurse indicated R51 would display one symptoms indicating a possible UTI (behaviors, confusion, agitation, blood pressure changes). On two occasions 2 symptoms were identified. The micro-organism was identified for three of the infections and each culture identified the same micro-organism. Two different antibiotics were identified used for the same micro-organism.

R14 developed 4 urinary tract infections between June 2014 and September 2014. Documentation completed by the infection control nurse indicated R14 had displayed only falls for 2 of the infections. The June infection documentation indicated 3 symptoms and the other infection documentation indicated 2 symptoms had been identified. Two different micro-organisms had been identified for the four infections. In June the infection control nurse noted the culture results were probably contaminated and the antibiotic was continued.

R20 developed 2 urinary tract infections. In each case only one symptom was identified. In each case two different organisms were identified for each infection.

R8 developed 2 urinary tract infections. Only one or two symptoms were identified. One infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 32 did not have an identified micro-organism and the other infection identified two micro-organisms responsible for the infection. R78 developed 2 urinary tract infections. R78 had a indwelling catheter. Two symptoms were identified for each infection, but only one infection identified the micro-organisms responsible (2 micro organisms). The infection control nurse documentation was reviewed. The documentation did not note that the number of identified symptoms present did not correspond to the policy (3 symptoms for non-catheter and 2 symptoms if catheter). The analysis provided for the quality committee did not identify trends of recurrent UTIs of or recurrent micro-organisms. The facility policy entitled Urinary Tract Infection (UTI) Prevention and Management dated 2/3/09 read, : 1. Do not treat asymptomatic UTI. Indications to treat UTI without a catheter should have 3 of the following::a) fever, b) increased burning, pain on urination, frequency, or urgency, c)new flank pain d)change in character of urine, e) worsening of mental or functional status. 2. Do not treat asymptomatic UTI. Indications to treat a UTI with a catheter must have 2 of the following: a) fever or chills b) new flank pain, c) change in character of urine." 22 other residents also had developed a single episode of UTI during the time period of April through October 2014. The infection control nurse documentation was reviewed. The reports lacked the 2 or 3 symptoms identified in accordance with the policy and the infection control nurse documentation lacked identification	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 33	21390		

of the micro-organism. The analysis of data provided by the director of nursing did not indicate a repetition of micro-organisms between residents with infections in a given month.

*April 2014 3 UTIs identified by the facility-one resident was not identified above. R19 had 3 symptoms listed, but no culture results. The infection control nurse had not documented on this resident.

*May 2014. 7 UTIs identified by the facility-5 not identified above. R67 had documentation that indicated only one symptoms (behavior change). The micro-organism was identified. R25 had one symptom of elevated temperature and also an elevated white count. The culture results were noted. R38 had only one symptom documented as an indicator of a UTI, no micro-organism was reported. R5 had one symptom documented as an indicator of a UTI and no micro-organism was reported. R44 had two symptoms documented as an indicator of a UTI and 2 micro-organisms were identified.

Review of the documentation provided indicated Proteus mirabilis, Klebsiella Pneumoniae, and E-coli were micro-organisms identified in 4 of the infections.

*June 2014 6 UTIs were identified by the facility-2 not listed as residents with multiple infections. R59 was admitted to the hospital with acute lower UTI. No information related to symptoms or culture results was identified on the hospital discharge summary or infection documentation. R75 had a catheter and had one symptom documented as an indicator of a UTI and also a urinalysis. Two micro-organisms were identified.

Review of the documentation of the 6 UTIs identified for the month three of the infections did not have micro-organisms listed by the infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00705	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 34 control nurse. *July 2014 4 UTIs were identified by the facility-3 not listed as residents with multiple UTIs. R12 had a catheter and had one symptom identified as an indicator or a UTI. No micro-organism was identified by the infection control nurse. R64 was admitted to the hospital with a diagnosis of UTI. The infection control nurse did not document symptoms or micro-organisms. R35 had two symptoms identified indicating a UTI and a micro-organism was identified. Review of the documentation provided indicated that all 4 infections lacked documented symptoms as identified by the policy and two lacked documented micro-organism. *August 2014 6 UTIs were identified for the month-3 were not identified as residents with recurrent UTIs. R31 had two symptoms indicating a UTI and a micro-organism listed. R56 had two symptoms and two micro-organisms identified. R55 had one symptoms listed and no micro-organism identified. Review of the infection control nurse documentation indicated only 4 of the 6 infections had identified micro-organisms and three of the 4 had the same organisms-E-Coli, Klebsiella Pneumoniae, and Proteus Mirabilis. Only one of the 6 residents had the symptoms identified in accordance with the facility policy. *September 2014 4 UTIs identified by the facility-three residents identified as having multiple/recurrent UTIs and are listed above. R6 had no symptoms indicating a UTI listed but had micro-organisms identified. Review of the infection control documentation indicated one of the reports had indicated symptoms identifying a potential UTI and only two had identified micro-organisms. *October 2014 3 UTIs were identified- 2 were not identified as having recurrent UTIs. R87 had one	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 35 symptoms identified indicating a UTI and a micro-organism listed. R999 had one symptom identified indicating a UTI and micro-organism identified. Review of the infection control documentation indicated two of the 3 UTIs had the same micro-organism identified-E-Coli and all lacked identifying symptoms according to the policy. A line listing of infections was provide on 11/17/14 at 7:45 p.m. by the director of nursing. She indicated this was the information provided to the quality assurance (QA) committee meeting. The line listing did not include the resident name, culture results, interventions or resolution. During an interview on 11/29/14 the director of nursing indicated infections were tracked on a map monthly to identify patterns. During an interview on 11/21/14 at 2:00 p.m. the administrator stated the infection rate and information was part of the QA committee process. During an interview on 11/25/14 at 10:44 a.m. the director of nursing (DON) indicated she felt the urinary tract infections were being analyzed and pattern. It had been determined that the four residents with catheters would chronically have bacteria and that the medical director had decided that these residents would no longer have urine cultures but rather white blood cell counts to determine a possible infection. The director of nursing indicated only 2 symptoms were necessary to determine a potential UTI and collect a urine culture as directed in the standing order. The symptoms would be determined by asking the resident, notifying changes in behavior, or past history. During the interview the director of nursing indicated if a resident had a potential UTI, staff were to encourage fluids, provide perineal care, offer reminders, and good	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 36	21390		

Continued From page 36

hand washing.
When reviewing the infection reports with the director of nursing on 11/25/14 at 2:30 p.m. she stated she realized that residents with catheters were having recurrent UTIs, but did not realize that other residents were also.
Lack of monitoring antibiotic effectiveness not tracked:
The facility's policy entitled Infection Control dated 12/12/13 indicated staff were to have appropriate in-service training on managing infections in residents. The policy also read, "Through ongoing monitoring this facility will take appropriate actions per State and Federal Guidelines to investigate, prevent, control and report disease and infection." The policy identified Tracking and trending Infections: as a) investigation, b)data collection as to type of infection, location, resident and facility or community acquired, c) calculate the data and compare rates over time to identify pattern, clusters, trends and opportunities for improvement, d) monitor for recurrent infections in residents.
During the interview on 11/25/14 at 10:44 a.m. the director of nursing stated the facility had a nurse dedicated to infection control and quality assurance. DON indicated it with the infection control nurse's responsibility to monitor and implement infection control program. The DON reviews the reports and takes this information to qualify committee. DON indicated the medical director was very involved with the infection control program and monitoring of infections.
During an interview on 11/25/14 at 10:52 a.m. the director of nursing indicated the facility would monitor micro-organisms, but not track antibiotics. She added on resident specific logs, infections, not antibiotic use was tracked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 37	21390		

Continued From page 37

The administrator was interviewed on 11/21/14 at 2:00 p.m. She indicated the medical director would be present at the quality assurance committee meeting and had input into the meeting. The infection control list of infections and re-occurring infections would be discussed and reviewed by the medical director. The administrator stated that she had not recognized the large number of UTIs. The infection control nurse tracks the UTIs and infections. The infection control nurse would be responsible to educate staff on perineal care. The administrator stated she had no concerns related to the number of UTIs at present.

SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing could in-service all employees on the basics of infection control practices to reduce and prevent the spread of infection.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21426 MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (21426)

(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 38 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly hired employees that worked directly with residents had received the two-step (two TB skin tests a few weeks from each other) tuberculin skin test (TST) for 1 of 6 employees (EE-A) hired in the past 4 months and the facility failed to provide annual tuberculosis prevention program training. Findings include: EE-A was hired on 10/13/14. On 9/19/14 EE-A received a TST at the clinic because she was a nursing student. The facility failed to ensure EE-A had received the second TST either from the clinic, school, or facility. On 11/20/14 at 9:15 a.m. the director of nursing (DON) was interviewed. DON stated EE-A had received step one at school, but there was no documentation of the second step and DON was unable to find any documentation related to EE-A receiving a second step before working with the residents. The facility policy dated 12/12/13 entitled Tb Risk Assessment Treatment and Prevention Plan read, "All employees will receive baseline two	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	**1635 WEST SERVICE DRIVE WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 39	21426		

step Tb screening upon hire."

Review of in-service training showed that 5 minutes of tuberculosis education was conducted on 4/11/13. There was no current information provided concerning the annual evaluation of the need for TB training by the facility or if actual training occurred following the 4/11/13 TB training. The goals/objectives indicated the training was on provision and reading of TST. During an interview on 11/25/14 at 10:30 a.m. the director of nursing stated the facility had not provided annual training of the tuberculosis treatment and prevention plan.

SUGGESTED METHOD OF CORRECTION:
The DON (Director of Nursing) could designate one staff to be in charge of ensuring 2-step tuberculin skin test are completed for employees upon hire. The DON could complete random audits to ensure continued compliance. In addition the director of nursing could review/revise the tuberculosis treatment and prevention plan to include annual staff training on all aspects of tuberculosis care, management, and prevention. The DON or designee could provide the education and monitor staff participation in the programs.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		

Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 40	21805		

employees of or persons providing service in a health care facility.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 2 of 2 residents (R27, R37) who ate in the main dining room and required assistance to eat their meals.

Findings include:

R27 and R37 were observed during a dining experience on 11/18/14 starting at 8:12 a.m. R27 and R30 were seated across from one another at the same dining room table with nursing assistant (NA)-B sitting in a chair to right of R27. At 8:21 a.m. NA-B was observed to be standing by the side of R37 and assisting her to eat bites of food. At 8:22 a.m. NA-B sat down in the chair by R27 and assisted her to eat her food. At 8:23 a.m. NA-B was observed to leave the table where he was assisting R27 and R37 to eat and was observed to pour another resident sitting at an adjacent table a cup of coffee. At 8:25 a.m. NA-B returned to sit by R27 and resumed assisting her to eat. At 8:30 a.m. NA-B was observed to be standing by R37 assisting her to eat. At 8:33 a.m. NA-B was observed to be standing by the side of R37 assisting her to eat bites of her food and take drinks of her fluids. At 8:35 a.m. NA-B was observed to be sitting down in the chair by R27 assisting her to eat her breakfast.

During an interview on 11/18/14 at 12:26 p.m. NA-D verified he was standing by R37 when he assisted her to eat her breakfast. NA-D stated she was a resident that only ate a few bites of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 41	21805		

Continued From page 41

food at a time and that was why he did not sit down by her. NA-D also stated he stood by R37 because if he did not get back to R27 quickly, R27 became agitated because you were helping somebody else and she won't eat. NA-D stated there were usually two more residents that sat at this table during meal time and there were usually two staff members at this table assisting residents that sat by each other to eat. NA-D stated R27 stopped eating towards the end of the meal as he had gotten up to many times when he was assisting her to eat to help other residents.

R27's nutritional care dated 5/29/13 read, "...has the potential to be at nutritional risk r/t [related to] diagnosis as well as need for staff assistance for all meals as well as varying intakes for these meals... Interventions: ...Staff to assist with all meals ..." The activity of daily living care plan dated 11/2/12 read, "...is totally dependent on two for all of her ADL'S [activities of daily living] This is a normal progression for end stage Lewy body dementia. Interventions: ...needs to be fed. She is totally dependent on one staff for all of her eating." The quarterly Minimum Data Set (MDS) assessment dated 10/30/14 indicated R27 required extensive assist of 1 staff for eating. The nutritional assessment dated 7/11/14 read, "...FEEDING: Extensive or total assistance with eating or drinking."

R37's nutritional care dated 8/22/14 read, "...has the potential to be at nutritional risk d/t [due to] advanced dementia m/b [may be] need for therapeutic diet as well as mechanically altered diet consistency per MD [medical doctor] order as well as varying intakes for all meals ... Interventions: Encourage [R37] to feed herself, and then assist with feeding when resident does not feed herself ..." The activity of daily living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 42	21805		

Continued From page 42

care plan dated 9/19/14 read, "... has an ADL [activity of daily living] Self Care Performance Deficit r/t [related to] impaired cognition and decreased functional status m/b [may be] requiring staff assistance with all ADLs... Interventions: ...requires extensive assistance of one staff with her meals. She needs encouragement to eat and will sometimes need to be fed (total) as she seems not to know what to do with the silverware on certain, less aware, days." The quarterly Minimum Data Set (MDS) assessment dated 10/28/14 indicated R37 required extensive assist of 1 staff for eating. The nutritional assessment dated 6/25/14 read, "...FEEDING: Able to feed herself ... Summary...is assisted in the dining room with meals."

During an interview on 11/20/14 at 2:34 p.m., the director of nursing stated she expected staff to be seated next to residents in the dining room when assisting them to eat their meals. The DON verified it was a dignity issue to stand by a resident and assist them to eat their meal.

The Feeding a Dependent Resident policy dated 11/6/13 read, "6. Tell the resident that you are going to be seated during the feeding, staff is to position a chair where it will be convenient for both them and the resident."

SUGGESTED METHOD OF CORRECTION:
The director of nursing could meet with the nursing staff responsible for assisting residents to eat to develop systems to ensure all residents are assisted to eat or fed in a dignified manner. The quality assessment and assurance committee could establish a system to audit dining to ensure compliance.

TIME PERIOD FOR CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 43 Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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21830	Continued From page 44 esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21830	Continued From page 45 enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide choices regarding bathing frequency for 1 of 3 residents (R70) reviewed for choices. Findings Include: R70's annual Minimum Data Set (MDS) dated 10/9/14, identified but not limited to diagnoses of Aphasia (unable to communicate accurately), cerebrovascular accident, atrial fibrillation and required physical help in part of bathing of one person physical assist. R70's brief interview for mental status (BIMS) score of twelve indicated moderate cognitive impairment. R70's plan of care (POC) dated 8/6/2014, read, "... has an actual self-care deficit as related to his CVA [cerebrovascular accident] with right sided hemiplegia ...Interventions ...needs the extensive assistance of one for bathing. He may be able to do some tasks, but limited as his dominant hand is not functioning due to his CVA [cerebrovascular accident]. His shower day is Monday in the PM [evening] ..."	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: ______ B. WING ______	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21830	Continued From page 46	21830		

R70 was interviewed on 11/18/2014 at 12:06 p.m., when asked, "Do you choose how many times a week you take a bath or shower?" R70 responded, " No! " and indicated one with his finger to answer how many times a week he had a shower or a bath. When asked if he would like more than one shower or bath a week, R70 shook his head indicating yes and indicated he would like three by holding up three fingers. When asked if he had told staff he would like more than one shower or a bath each week R70 shook his head yes.

During an interview on 11/21/14, at 11:18 a.m., registered nurse (RN)-B stated it was standard in the facility for bathing one time a week unless a resident requested additional baths or we have a physician order specifying bathing frequency. RN-B stated the bathing schedule was based on room location unless there was a specific request or preference based on evening or morning. RN-B stated when I visit with residents upon admission, I let them know their shower or bath is on a specific day. RN-B stated I instruct residents about our bathing process informing them baths are provided one time a week, with sponge bathing twice a day. RN-B stated I inform residents they just need to let staff know if they would like additional baths and stated the facility will accommodate requests. RN-B stated she spoke with R70 regarding his preference for bathing frequency and R70 will be scheduled for bathing two times per week per their conversation.

A policy for bathing choices was requested and not provided.

SUGGESTED METHOD OF CORRECTION:

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21830	Continued From page 47 The administrator could in-service all employees on the need for self choice in residents choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not	21880		

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21880	Continued From page 48	21880		

otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to address cool room complaints timely for 1 of 6 residents (R24) reviewed in the sample on west wing with cold room complaints.

Findings include:

R24 complained of cold room temperatures. During interview on 11/18/14, at 8:58 a.m., stated the room was cold. R24 stated had reported the cold room to staff. Observations at that time revealed R24's bed was positioned by the window. R24 sat in a wheelchair and R24 was covered with a sweater and blanket.

During environment tour on 11/20/14, at 1:30 p.m., director of environmental services (DES-A) verified the cold rooms for R24. DES-A stated he spot checked room temperatures only if there was a complaint. He stated last week the facility had cold temperature complaints on east wing which he repaired. He stated he was not aware of cold room complaints on west wing.

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21880	Continued From page 49 Document review of facility physical environment policy dated 10/1/09-patient environment: #2. "There is adequate heating system to maintain comfortable temperatures of at least 71 degrees during the heating system." SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff responsible for addressing resident complaints to act upon them timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		