DEPARTMENT OF HEAL						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: 27LG
					IE SURVEI AGENCI	Facility ID: 00705
1. MEDICARE/MEDICAID PROVI (L1) 245102	DER NO.	3. NAME AND AI (L3) SAUER HEA		ILIIY		4. TYPE OF ACTION: <u>7</u> (L8)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1635 WEST	SERVICE DR	IVE		1. Initial2. Recertification3. Termination4. CHOW
(L2) 493543800		(L5) WINONA, N	4N		(L6) 55987	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE O	FOWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Full Survey Arter Complaint
 6. DATE OF SURVEY 02, 8. ACCREDITATION STATUS: 	/24/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE	09/30
2 AOA 3 Other						
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia			And/Or Approved Waivers Of	
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	71 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F)8. Patient Room Size
	(117)	B Not in Con	pliance with Prog	ram	5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	71 (L17)	Requireme	ents and/or Appli	ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKE	OOWN				15. FACILITY MEETS	
18 SNF 18/19 SNI	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
71						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Marietta Lee, HFE NE	II	0	3/23/2015		Kamala Fiske-Downing, I	Enforcement Specialist 04/07/2015
P	ART II - TO BE (COMPI ETED I	RV HCFA RF	(L19)	L OFFICE OR SINGLE S	(L20)
19. DETERMINATION OF ELIGIB			IPLIANCE WITH ITS ACT:		2. Ownership/Contro	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	-				3. Both of the Above	:
2. Facility is not Eligit	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING		ENDING DAT		VOLUNTARY 00	
01/19/1967					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	······································
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active
		1	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
				DATE		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 01/07/2015	OF APPROVAL	DATE		
	(L32)	01/07/2013		(L33)	DETERMINATION APPE	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 27LG
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00705

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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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.

Sauer Health Care February 10, 2015 Page 2

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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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

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 245102	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
	F0241 483.15(a)	(Correction Completed 02/19/2015		F0282 483.20(k)(3)(ii)		Correction Completed 02/19/2015			F0310 483.25(a)(1)		Correction Completed 02/19/2015
ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 02/19/2015		F0441 483.65		Correction Completed 02/19/2015		D.a. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed				Correction Completed		Reg. #			Correction Completed
Reg. #			Correction Completed									
			Correction Completed	Reg. #								
Reviewed I		eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen Reviewed I CMS RO		PN/kfd eviewed	Ву	03/23/2013 Date:	5 Signature	of Sur	154 veyor:	25			Date:	02/24/2015
Followup t	o Survey Comp 11/25/2		:		Check for any Uncorrected					Summary of the Facility?	YES	NO



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,

Kumala Fiske Downing

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

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00705	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/24/2015
Name	e of Facility		Street Address, City, State, Zip Code	
SA	UER 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y	5) C	ate
ID Prefix	20565	Correction Completed 02/19/2015	ID Prefix		Correction Completed 02/19/2015	ID Prefix	21390		Correction Completed 02/19/2015
	MN Rule 4658.0405 Su			MN Rule 4658.0525 Sub			MN Rule 4658.0		
	21805 MN St. Statute 144.651		Reg. #		Correction Completed	Reg. #			
ID Prefix Reg. # LSC			Reg. #		Correction Completed	ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Dog #			
ID Prefix Reg. # LSC			Reg. #		Correction Completed				Correction Completed
Reviewed E State Agend		і Ву	Date:	Signature of Sur	veyor:		ſ	Date:	
Reviewed E CMS RO	-	іВу	Date:	Signature of Sur	veyor:		[Date:	
	o Survey Completed of 11/25/2014			Check for any Uncor Uncorrected Defic			the Facility?	YES	NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 27LG
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00705
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245102	ł	3. NAME AND AI (L3) SAUER HE A	ALTH CARE			 4. TYPE OF ACTION: <u>7</u>(L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 493543800).	(L4) 1635 WEST (L5) WINONA, N		RIVE	(L6) 55987	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OV (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 01/22	/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGURE VEAD ENDING DATE (122)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With			The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	71 (L18)	•	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	71 (L17)	X B. Not in Con Requirement	npliance with Pro- ents and/or Appl			(L12)
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	
18 SNF 18/19 SNF 71	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Kyla Einertson, HFE NE I</u>	[0	2/12/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 03/24/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBILIT _X_ 1. Facility is Eligible to Particular 			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>	
01/19/1967	(1.41)		(1.25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI	VESANCTIONS	(L25)		03-Risk of Involuntary Terminatio	-
25. LIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	DATE		
	(L32)	01/07/2015		(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 27LG PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00705

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:

Sauer Health Care January 29, 2015 Page 2

• 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Sauer Health Care January 29, 2015 Page 4

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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,

Kumala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

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 245102	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/22/2015
Name	of Facility		Street Address, City, State, Zip Code	
SA	UER 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	(Y4) Item	(Y5) Date	(Y4)	ltem		(Y5)	Date
	F0166 483.10(f)(2)	(Correction Completed 01/04/2015		F0242 483.15(b)	Correction Completed 01/04/2015			F0272 483.20(b)(1)		Correction Completed 01/04/2015
ID Prefix Reg. # LSC	F0278 483.20(g) - (i)	(Correction Completed 01/04/2015	ID Prefix Reg. # LSC	F0279 483.20(d), 483.20(k)(1)	Correction Completed 01/04/2015		ID Prefix Reg. # LSC	483.20(d)(3), 4	483.10(Correction Completed 01/04/2015 k)(2)
ID Prefix Reg. # LSC	F0371 483.35(i)	(Correction Completed 01/04/2015	Reg. #		Correction Completed		Reg. #			Correction Completed
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State Agen	cy Gl	PN/KI	FD	02/12/20	0	•	1221			0	1/22/2015
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Followup t	o Survey Comple 11/25/20				Check for any Unco Uncorrected Defi					YES	NO

		AND HUMAN SERVICES		FOR	M APPROVED
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		245102	B. WING _	0	1/22/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER H	IEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987	
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{F 000}	INITIAL COMMENT	-S	{F 000)}	
	completed on Janu certification tags tha found on the CMS2 that were not found	ification revisit (PCR) was ary 21 & 22, 2015. The at were corrected can be 567B. Also there were tag/s corrected and/or new tags time of onsite PCR which are 62567.			
	signature is not req				
{F 241} SS=E	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with AND RESPECT OF	{F 241	1}	2/19/15
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.			
	by: Based on observat review the facility fa dining service for 4	NT is not met as evidenced ion, interview and document iled to provide a dignified of 20 residents (R46, R62, erved during the dining		In response to the above stated citation Sauer Health Care has taken the followir action: " A coaching and re-education was completed on 2/17/2015 with staff member observed by state surveyor in th dining area where the following issues	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE

Electronically Signed

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.

02/19/2015

PRINTED: 03/04/2015

		& MEDICAID SERVICES			OMB NO.	0930-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
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	noviden on our lien			1635 WEST SERVICE DRIVE		
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{F 241}	Continued From pa	ae 1	{F 24	1}		
{F 241}	R46, R62, R55, R5 staff for eating assis- timely and consiste dignified dining exp provided. Nursing assistant (I table with R46, R62 a.m. NA-A was obs attempted to feed s remained seated w although their food 11:47 NA-A returne and set up drinks for walked around the R46 to assist them R62 remained sittin being encouraged to assisted R46 to pla p.m. R55 was obse being encouraged to observed to move to assist them to eat a cued to eat for the p warmed the meal for to assist them to eat NA-A was interview NA-A stated only or help at the restoratii included R58, R46, that R62 would new had advanced dem	8 who were dependent on stance were not provided nt assistance to ensure a erience for each resident was NA)-A was observed sitting at 2, R55, and R58. At 11:44 erved to leave the table R46 eelf while the other residents ith no attempt to feed self was sitting in front of them. At d to sit between R62 and R55 or them, then NA-A got up and table to sit between R58 and to eat. At 12:03 p.m. R55 and g at the table not eating or by staff to eat the meal. NA-A ce food on the fork. At 12:08 rved not to eat and was not or assisted to eat. At 12:12 bing at the table and had not o eat. At 12:14 p.m. NA-A was between R58 and R55 to as they had not been helped or bast 24 minutes. NA-A had not or R58 and R55 before starting	{F 24	1} were noted: getting up and lead table with residents present at having other assistance present offering cuing or encouragem needed to residents, not atten wake sleeping residents for di- attempting to warm food that it observed to be at the table for before attempting to assist resi- food. "Following the exit of the si- team a message was sent to and the dietary manager from administrator on 2/2/2015 direct following changes to be maded immediately in the dining room further discussion and plannin ongoing to make improvement oFollowing service of the m dietary staff member will remand dining room throughout the m stop at tables to question if an needed by residents or nursin members to eliminate the need nursing staff to get up and inter dining assistance being provid "On 2/5/2015 a message w from the administrator to the r team indicating that Pathway been contacted and arrangem been made for a consultant to facility on 2/18/2015 and 2/19, observe the dining process ar make recommendations on he improve the process to ensure experience for all residents. T implemented as appropriate for	nd not ent, not ent as opting to ning and not had been 24 minutes sident to eat tate survey the DON the octing the eat and will of for errupt the ded. vas sent management Health had nents have o visit the 2015 to nd then ow to e a dignified hese will be	

Facility ID: 00705

If continuation sheet Page 2 of 22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245102	B. WING		R 01/22/2015
	PROVIDER OR SUPPLIER	243102	2	STREET ADDRESS, CITY, STATE,	
	IEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987	
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{F 241}	only one staff memi residents at the resi- have only residents program. DON stati other staff did not a help. R46 did not receive during the meal ser dining experience. a.m. to 12:00 p.m. wheelchair while a p her at the table. No assist her with eatir was observed to ke away from the table assistant would pus time NA-A stood for her to eat and assis R46's care plan prir self-care deficit and feed herself, but pe assistance. During an interview director of nursing (cued for eating. R62 did not receive during the meal ser dining experience. lunch meal on 1/22, p.m. R62 made no For a short time NA and then left R62 to	ge 2 ng (DON) stated that usually ber was assigned to assist torative table which should that need a restorative dining ted she did not know why ssist when residents needed the assistance she needed vice to promote a dignified R46 was observed from 11:10 to be sleeping in the olate of food was in front of o staff was sitting beside her to ag or to cue her to eat. R46 ep pushing the wheelchair e and the nurse or nursing sh her back to the table. At one r a few minutes to encourage sted her with cutting the food. nted 1/22/15 identified I indicated R46 was able to rhaps needed some at 4:30 p.m. on 1/22/15 the DON) stated R46 was to be the assistance she needed vice to promote a dignified R62 was observed during the (15 from 11:05 a.m. to 12:00 attempt to eat independently. -A assisted the resident to eat o help another resident then s observed to cut R62 food.	{F 24	 dining were modified or R62 care plan and dining were modified or Additional modifications 2/19/2015. "R55 care plan and dining were modified or "R58 care plan and dining were modified or "R58 care plan and dining were modified or "R58 care plan and dining were modified or "A survey that was or dietary manager will be residents who are able by 3/31/2015 to evaluat with their dining experies suggestions on how to overall experience. "This survey was las February, 2014. "Specific designation dining table has been e following message bein on 2/20/2015: There will no longer table for restorative dinir residents have dining o considered restoratives eat, staff placing food o then having the resident having the resident having them drink it ind these tasks can be con restorative form of dinir member can provide th trained in dining assistar restorative staff member dining area for all meals will not be solely respored. 	directives for 1 2/14/2015. a were made on directives for 1 2/14/2015. directives for 1 2/14/2015. created by the completed with all to be interviewed the their satisfaction ence and to offer improve their at completed n of restorative liminated with the ng delivered to staff r be a designated ing. Several of our rders that can be such as cuing to in a utensil and it place food in placing a its hand and ependently. All of sidered a ng and ANY staff is service as all are ince. The ers will be in the s as in the past but

Facility ID: 00705

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED R
	245102	B. WING _				י 22/2015
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was to be provided	meals at the restorative dining			needs it based on their care plan directives. " The following message is being		
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.				 Anytime a change in a resident ability to complete dining tasks as indicated is noted staff is to immed 	iately	
during the meal ser dining experience. on 1/22/15 from 11: made no attempt to cueing and NA-A as	vice to promote a dignified R55 was observed at lunch 25 am to 12:00 p.m. and eat independently or with ssisted her intermittently while			can be evaluated for needed chang modifications and updates. " An audit of the dining experien be completed randomly to ensure a dignified dining experience.	room seating changes, perience will isure a	
R55 ' s care plan pr was on the restorat eating/swallowing. promote independe needed for task cor the care plan identi- deficit and indicated assistance for eatin	rinted 1/22/15 indicated R55 ive nursing program for Staff was to provide cueing to ent eating and assistance as mpletion. In another area of fied a problem of self-care d R55 needed extensive	two residents." All staff will be educated via electronic mailing, paper communication binder in the and/or through their departm communication methods by a with a live in-service planned and dietary staff members of All nursing and dietary staff r have completed live in-service 3/31/2015 with others indicated	via electronic mailing, paper copy in communication binder in the break and/or through their department communication methods by 2/20/20 with a live in-service planned for nu and dietary staff members on 3/5/2 All nursing and dietary staff member have completed live in-service train 3/31/2015 with others indicating knowledge of plan as stated above	n room 015 irsing 015. ers will ing by		
					In	
during the meal ser dining experience. noon meal on 1/22/ 12:00 p.m. and rece to eat by NA-A who	vice to promote a dignified R58 was observed during the 15 between 11:35 a.m. and eived intermittent assistance was helping several residents			be the responsibility of the RN unit managers and the licensed staff as as certified nursing assistants and staff members with overall complia being the responsibility of the Direct	well dietary nce tor of	
	(EACH DEFICIENCY REGULATORY OR L REGULATORY OR L Continued From pa R62's care plan prin was to be provided table and that staff resident to eat. During an interview director of nursing (totally assisted to e R55 did not receive during the meal ser dining experience. on 1/22/15 from 11: made no attempt to cueing and NA-A as going back and fort R55 ' s care plan privas on the restorat eating/swallowing. promote independen needed for task cor the care plan identi deficit and indicated assistance for eatin During an interview director of nursing s eating. R58 did not receive during the meal ser dining experience. noon meal on 1/22/ 12:00 p.m. and receive during the meal ser	PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIC TAG Continued From page 3 {F 24 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. {F 24 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.	PROVIDER OR SUPPLIER I HEALTH CARE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 3 {F 241} 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. {F 241} 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.	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE ISSUMMARY STATEMENT OF DEFICIENCIES IND SUMMARY STATEMENT OF DEFICIENCIES IND PROVIDER'S PLAN OF CORRECTION REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION Continued From page 3 IND PROVIDER'S PLAN OF CORRECTION RG2's care plan printed 1/22/15 indicated R62 IND PREFIX Variang an interview at 4:30 p.m. 1/22/15 the to offer assistance to any resident to ast. During an interview at 4:30 p.m. 1/22/15 the Indicated R62 was to be The following message is being director of nursing (DON) stated R62 was to be to offer assistance to any resident to ast. The following message is being R55 did not receive the assistance she needed during the meal service to promote a dignified The following to staff members on 3/5/2 R55 's care plan printed 1/22/15 indicated R55 was on the restorative nursing program for An audit of the dining experience. reading/swaldowing. Staff Was to provide cueing to In and modification binder in the break an indicated R55 needed extensive assistance for eating During an interview at 4:30 p.m. 1/22/15 the In an indentified a problem of self-care deficit and indicat	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE 100 JP SUMMARY STATEMENT OF DEFICIENCIES ID IRECHT DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ATON SHOULD BE CROSS-REFERENCE DO THE APPROPRIATE DEFICIENCY) Continued From page 3 FF 2411 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. FF 2411 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. FF 2411 R55 did not receive the assistance she needed during the meal service to promote a dignified dining experience. The following message is being is edivered to staff on 2/20/2015: o Arytime a charge in a residents ability to complete dining tasks as indicated is noted staff members on the current care plan and dining experience. 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 taing 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. Na staff werebers of nursing and dietary staff members will have completed live in-service training by 3/31/2015 with others indicating hrowledge of plan as stated above

Facility ID: 00705

If continuation sheet Page 4 of 22

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDII	NG		R
		245102	B. WING _			22/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER I	HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETIC DATE
{F 241}	Continued From pa self-care deficit and assistance with eat	that R58 needed limited	{F 24	1}		
{F 282} SS=E	director of nursing i assisted to eat. DC restorative table an program. Also DOI the meal for R58, p provided hand over	on 1/22/15 at 4:30 p.m. the ndicated R58 was to be totally DN stated R58 sat at the d had a restorative dining N said that staff was to set-up rovide verbal cues, and hand assistance as needed. RVICES BY QUALIFIED ARE PLAN	{F 28	2}		2/19/15
	must be provided b	led or arranged by the facility y qualified persons in Ich resident's written plan of				
	by: Based on observat review the facility fa care plan which wa comprehensive ass (R46, R62, R55, R5 with eating; the faci care plan for 1 of 1 change in health sta been contacted tim follow 1 of 3 resider personal hygiene no Findings include:	NT is not met as evidenced tion, interview and document ailed to follow each resident's s developed based on the sessment for 4 of 20 residents 58) needing staff assistance lity failed to follow a hospice resident (R14) who had a atus and physician had not ely; lastly the facility failed to nts (R54) care plan addressing eeds.		In response to the above stated Sauer Health Care has taken the action: " A coaching and re-education completed on 2/17/2015 with staf member observed by state surve dining area where the following is were noted: getting up and leavin table with residents present and r having other assistance present, offering cuing or encouragement needed to residents, not attempti wake sleeping residents for dining attempting to warm food that had observed to be at the table for 24 before attempting to assist reside food.	following was f yor in the sues g the not not as ng to g and not been minutes	

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If continuation sheet Page 5 of 22

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION ((X3) DATE	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED	
		245102	B. WING			F 01/5	- 22/2015	
NAME OF I	PROVIDER OR SUPPLIER		I		TREET ADDRESS, CITY, STATE, ZIP CODE	01/2	22/2015	
SAUER I	HEALTH CARE			1	635 WEST SERVICE DRIVE VINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE	
{F 282}	R46, R62, R55, R5 11:05 a.m. to 12:00 designated for resid assistance to eat the R46 was observed and was observed wheelchair while R4 uncovered. No stat assist her with eatin was observed to ke away from the table assistant would pus staff stood to encou- her with cutting the of the meal. The care plan printe deficit. The care pl feed herself, but per assistance to open dining room were re also indicated staff eat. During an interview director of nursing cued for eating. The to take a fork to her have food on the for encourage R46 to e talk to R46 across the	8 observed on 1/22/15 from p.m. seated at a table dents who needed staff heir meals. from 11:10 a.m. to 12:00 p.m. to be sleeping in the 46's food sat in front of her ff was sitting beside her to ng or to cue her to eat. R46 eep pushing the wheelchair e and the nurse or nursing sh her back to the table. One urage her to eat and assisted food. R36 ate less than 25% ed 1/22/15 identified self-care an indicated R46 was able to erhaps needed some things, but most items in the eady to eat. The care plan was to be there to help R46 at 4:30 p.m. on 1/22/15 the (DON) stated R46 was to be he DON stated R46 was able r mouth, but did not always ork. DON stated NA-A should eat and that it would be okay to	{F 2	82}	 Following the exit of the state sutteam a message was sent to the DC and the dietary manager from the administrator on 2/2/2015 directing t following changes to be made immediately in the dining room while further discussion and planning was ongoing to make improvements: Following service of the meal a dietary staff member will remain in th dining room throughout the meal and stop at tables to question if anything 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 see from the administrator to the manag team indicating that Pathway Health been contacted and arrangements he been made for a consultant to visit the facility on 2/18/2015 and 2/19/2015 to baserve the dining process and thermake recommendations on how to improve the process to ensure a dig experience for all residents. These wimplemented as appropriate following exit report findings. R46 care plan and directives for dining were modified on 2/14/2015. Additional modifications were made 2/19/2015. 	DN the he d will is the nt ement had have he to n nified will be ng her		
	1/22/15 from 11:05 no attempt to feed a resident to eat. NA provide guidance for	during the lunch meal on a.m. to 12:00 p.m. R62 made self. NA-A assisted the -A was not observed to or eating safely or encouraged one point NA-A left R62 and			 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 			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245102	B. WING				੨ 22/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				16	635 WEST SERVICE DRIVE		
SAUER	HEALTH CARE				/INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	at a potential for nu provided meals at the The care plan direct resident to drink, to degrees, to encoura double swallow. In the interventions not dependent on staff During an interview director of nursing (totally assisted to east should not be seated she is unable to east R55 was observed am to 12:00 noon. If and made no attem The care plan printe on the restorative ne eating/swallowing. promote independeneeded for task corr the care plan identified deficit and indicated assistance for eatinne eating process. The needed encourager fed. During an interview director of nursing se eating.	A62 food. ed 1/22/15 indicated R62 was tritional risk and was to be he restorative dining table. ted staff were to encourage tuck chin, to sit at 90 age through clearing and another area of the care plan ted R62 was totally to eat. at 4:30 p.m. 1/22/15 the DON) stated R62 was to be at. The DON stated R62 ed at the restorative table if independently. at lunch on 1/22/15 from 11:25 R55 was being fed by NA-A pt to feed herself.	{F 2	82}	dietary manager will be completed or residents who are able to be intervise by 3/31/2015 to evaluate their satisfi with their dining experience and to or suggestions on how to improve their overall experience. " This survey was last completed February, 2014. " Specific designation of restorated dining table has been eliminated wit following message being delivered on 2/20/2015: o There will no longer be a design table for restorative dining. Several residents have dining orders that cat considered restorative such as cuine eat, staff placing food on a utensil at then having the resident place food mouth themselves and placing a beverage in the residents hand and having them drink it independently. these tasks can be considered a restorative form of dining and ANY member can provide this service as trained in dining assistance. The restorative staff members will be in dining area for all meals as in the p will not be solely responsible for designated residents. All staff is ex to offer assistance to any resident v 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 resident ability to complete dining tasks as indicated is noted staff is to immedin notify a licensed staff member so th current care plan and dining room s	ewed faction offer ir live th the to staff nated l of our an be og to and in All of staff s all are the ast but spected who s ately ne	

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		AND HUMAN SERVICES				FORM	03/04/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY PLETED
		245102	B. WING				२ 22/2015
NAME OF	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SAUER	HEALTH CARE				635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	1/22/15 between 11 was being fed by N The care plan print deficit and that R58 with eating. The ca R58 needed assista at times needed to NA-A was interview NA-A stated only or help at the restorati R62 would never fe advanced dementia help. NA-A stated I feed self but neede During an interview director of nursing (one staff member v restorative table wh that need a restoratist stated she did not k assist During an interview director of nursing i fed. DON stated R and had a restorative to set-up the meal f and provided hand needed. DON stated the facility hoped w needed to be updat Lack of timely notifier R14's interdisciplina	1:35 a.m. and 12:00 N. R58 A-A. ed 1/22/15 indicated self-care a needed limited assistance are plan interventions indicated ant with set up and cueing and be actually fed. red at 12:00 noon on 1/22/15. ne person was assigned to ive nursing table. She added eed herself and that R58 had a and at times also needed R55 and R46 were able to d encouragement to do so. on 1/22/15 at 4:30 p.m. the (DON) stated that usually only vas assigned to assist at the nich should have only residents tive dining program. DON know why other staff did not on 1/22/15 at 4:30 p.m. the ndicated R58 was to be totally 58 sat at the restorative table ve dining program. Staff was for R58, provides verbal cues, over hand assistance as ed R58 should have finger the care plan identified what ould be provided and now	{F 2	82}	can be evaluated for needed chang modifications and updates. "Coaching and education was p on 2/17/2015 to the staff member identified as working on 1/19/2015 the failure to complete proper notifi was indicated. "The policy Change of Condition Physician Notification dated 11/11/2 was modified on 2/14/2015 with ch title as follows: Change of Conditio Provider Notification and directives need to notify Hospice services wa added. "The job description for Trained Medical Assistant was reviewed an to be current and appropriate with directive being present on the need consult with a licensed staff membe before providing any as needed PF medications. "The following message is being delivered to staff on 2/20/2015: oAny changes in resident condit status that is considered to be sign or not normal per baseline status n communicated to a provider and w applicable to Hospice Service Ager oTMA staff MUST consult with a licensed staff member prior to administration of ANY as needed, F medications. oA licensed staff member MUST an evaluation/assessment note in t permanent record to indicate the indication sthat are administered TMA based on that nurse s directi "Shaving was provided to R54	orovided when cation n, 2014 ange of n, of the s d found d to er RN g is ion or ificant nust be hen ncy. PRN F make he l by a	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		IPLETED
		045100	B. WING			R
		245102	D. WING			22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1635 WEST SERVICE DRIVE		
SAUER	HEALTH CARE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
{F 282}	Continued From pa	ae 8	/F 29	821		
{F 282}	chest pain and state medication adminis R14 was administe (anti-anxiety medica 6:40 p.m. and 7:50 Duoneb (respiratory needed morphine (i between 6:10 p.m. of the MAR indicate needed morphine, i other time from Jan 2015. The IDT progress r and it read a nurse sounds, but had no practitioner or hosp deterioration of hea interdisciplinary pro through 1/21/15 did physician (MD), nur hospice nurse. R14's care plan prin myocardial infarctio artery disease (CAI staff to monitor/doc practitioner or medi symptoms of CAD, shortness of breath hospice form direct condition, hospice s notified. The direc interviewed on 1/22 she was unaware o check with the LPN	a, sweating, and complained of ed, "Help me." The stration record (MAR) noted red as needed Lorazepam ation), three times between p.m. on 1/19/15; as needed y medication) one time; and as narcotic pain medication) twice and 9:30 p.m. Further review ed R14 had not received as Lorazepam or Duoneb at any nuary 1, 2015 to January 22, note dated 1/19/15 at 6:17 p.m. had assessed lung and heart t notified the physician, nurse	{F 2	 immediately on 1/21/201 of finding of hairs presenupper lip. "R54 care plan for pehygiene/oral care was modeled 2/14/2015. "An alert was set up of the PCC system to indicate staff when the task of shadocumented as not being hours or more. "The following messation staff on 2/16/2015: As a part of our plan following the recent revise shaving has been added resident as a daily task the signed off on. An alert has trigger to the dashboard indicates anything other the answer to this task. "Audit that was estable the initial survey will have increased and will be ong "An audit of the dining be completed randomly the EduCare training modeled cares. This module inclustation assessment have this completed 4/7//" All staff will be educate via electronic mailing, pa communication binder in 	t on neck and rsonal odified on on 2/16/2015 in ate to the licensed aving is g done for 48 ge was sent out of correction it from the state, to EVERY hat needs to be as been set up to if the CNA than yes as an ished following e frequency going. g experience will o ensure a ce. been assigned dule Personal udes shaving. lete a skills ent and all will 2015. tted on this plan per copy in	

Facility ID: 00705

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/04/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245102	B. WING				ך 2 2/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALLED	HEALTH CARE			1	635 WEST SERVICE DRIVE		
SAUER				W	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	DON verified the do that an assessment medications were g DON stated she did nurse on duty that everified the docume physician, nurse pra notified as directed facility policy Chang Notification dated 1 policy read, "The at physician/NP on ca in a resident's cond policy also identified breath and chest pa that were to be repa also directed the ch to be notified. Lack of providing na plan: R54 was observed long white facial ha and facial hair on h The quarterly Minim indicated R54 had a status score of 6 wl impairment, require staff with personal I 9/22/13 indicated R daily living] Self Can [related to] her dem only with her ADLs. is able to do her ow needs to be superv flow sheet indicated R	be umentation did not indicate twas completed before the iven. On 1/22/15 at 2:40 p.m. I not know if the registered evening had been notified and entation did not indicate the actitioner or hospice had been in the plan of care. The ge of Condition, Physician 1/11/14 was reviewed. The tending physician or II will be notified with changes ition or health status" The d symptoms of shortness of ain as changes in condition orted. The policy procedure large nurse or supervisor was all care as directed on the care on 1/21/15 at 1:05 p.m. with ir on the left side of her neck er upper lip. num Data Set dated 12/9/14 a brief interview for mental nich indicated severe cognitive d limited assistance of one nygiene. The care plan dated 54 had, an "ADL [activity of re Performance Deficit r/t ientia. She needs supervision " Interventions included, "R54 in personal cares, but again ised." The nursing assistant d R54 required supervision ly living and directed staff to	{F 2	82}	and dietary staff members on 3/5/2 All nursing and dietary staff member have completed live in-service train 3/31/2015 with others indicating knowledge of plan as stated above same date. Compliance for adherence to this p be the responsibility of the nursing department staff members with ove compliance being the responsibility Director of Nursing Services.	ers will ning by by this plan will erall	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY
							R
		245102	B. WING			01/2	22/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SAUER H	IEALTH CARE			-	35 WEST SERVICE DRIVE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From pa	ge 10	{F 28	32}			
		her neck and upper lip was bservation by the director of /21/15 at 2:02 p.m.					
{F 310} SS=E	care plan read, "Is a cares, but again ner stated this would in DON verified the far plan for personal hy	p.m. the DON verified R54's able to do her own personal eds to be supervised" and clude facial hair removal. The cility did not follow the care /giene for R54. DO NOT DECLINE UNLESS	{F 3 [.]	10}			2/19/15
	resident, the facility abilities in activities unless circumstanc condition demonstra unavoidable. This i to bathe, dress, and ambulate; toilet; eat	rehensive assessment of a must ensure that a resident's of daily living do not diminish es of the individual's clinical ate that diminution was includes the resident's ability d groom; transfer and t; and use speech, language, communication systems.					
	by: Based on observat review the facility fa to assist the resider for 4 of 4 residents reviewed during din residents (R54) had Findings include: R46, R62, R55 and	NT is not met as evidenced ion, interview and document iled to provide dining services nt to maintain or gain abilities (R46, R62, R55 and R58) ing and failed to ensure 1 of 3 d facial hair removed. R58 were observed on a.m. to 12:00 p.m. R46, R62,			In response to the above stated cit Sauer Health Care has taken the for action: " A coaching and re-education was completed on 2/17/2015 with staff member observed by state surveyo dining area where the following issu- were noted: getting up and leaving table with residents present and not having other assistance present, no offering cuing or encouragement as	Ilowing as r in the les the t t	

Facility ID: 00705

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PRINTED: 03/04/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES			ON		APPROVEI 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245102	B. WING			F	
	PROVIDER OR SUPPLIER	245102	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	01/2	22/2015
NAME OF I	FROVIDEN ON SUFFLIEN				635 WEST SERVICE DRIVE		
SAUER I	HEALTH CARE				VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
{F 310}	facility as the restor residents needed v to eat. R46 was observed R46 was observed wheelchair while th the table. No staff her with eating or to observed to keep p from the table and would push her bac stood for a few mor and assisted her w left R46 ' s care plan p self-care deficit. Th was able to eat ind some assistance to in the dining room v plan also indicated R46 eat. During an interview nursing assistant (If feed self but needed During an interview director of nursing cued for eating. Th to take a fork to he have food on the for encourage R46 to of R62 was observed	t a table designated by the rative table which means the various amounts of assistance from 11:10 a.m. to 12:00 p.m. to be sleeping in the re food was in front of her at was sitting beside her to assist o cue her to eat. R46 was oushing the wheelchair away the nurse or nursing assistant ck to the table. One nurse ments to encourage her to eat ith cutting the food and then rinted 1/22/15 identified he care plan indicated R46 ependently however, needed o open things, but most items were ready to eat. The care staff was to be there to help v on 1/22/15 at 12:00 p.m. NA)-A stated R46 was able to ed encouragement to do so. v at 4:30 p.m. on 1/22/15 the (DON) stated R46 was to be the DON stated R46 was able r mouth, but did not always ork. DON stated NA-A should eat.	{F 31	10}	needed to residents, not attempting wake sleeping residents for dining a attempting to warm food that had be observed to be at the table for 24 m before attempting to assist resident food. "Following the exit of the state su team a message was sent to the DG and the dietary manager from the administrator on 2/2/2015 directing following changes to be made immediately in the dining room while further discussion and planning was ongoing to make improvements: oFollowing service of the meal a dietary staff member will remain in t dining room throughout the meal an stop at tables to question if anything needed by residents or nursing staff members to eliminate the need for nursing staff to get up and interrupt dining assistance being provided. "On 2/5/2015 a message was set from the administrator to the manage team indicating that Pathway Health been contacted and arrangements been made for a consultant to visit to facility on 2/18/2015 and 2/19/2015 observe the dining process and the make recommendations on how to improve the process to ensure a dig experience for all residents. These of implemented as appropriate following exit report findings. "R46 care plan and directives for dining were modified on 2/14/2015.	and not een inutes to eat urvey ON the e s the nd will g is f the ent gement had have the to n gnified will be ng her r	
	no attempt to eat in	a.m. to 12:00 p.m. R62 made idependently. NA-A ed the resident to eat and			" R62 care plan and directives for dining were modified on 2/14/2015. Additional modifications were made		

Facility ID: 00705

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		PLETED
		245102	B. WING			R 22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	22/2015
SAUER I	HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 310}	assisted another re R62 to eat. R62 's care plan pr had the potential fo provided meals at t The care plan direct resident to drink, to swallowing, to sit at through clearing an The quarterly Minim indicated R62 requi- eat. During an interview NA-A stated R62 ne needed full assistant at 4:30 p.m. 1/22/13 stated R62 was to b R55 was observed am to 12:00 p.m. by NA-A and R55 m independently. R55 's care plan pr was on the restoratt eating/swallowing. promote independen needed for task cor During an interview NA-A stated R55 w but needed encoura- interview at 4:30 p.1	helping R62 eat food NA-A sident and did not encourage rinted 1/22/15 indicated R62 r nutritional risk and was to be he restorative dining table. ted staff were to encourage tuck chin to promote safe 90 degrees, to encourage d double swallow. hum Data Set dated 11/18/14 ired extensive assist of one to r on 1/22/15 at 12:00 p.m. ever eaten independently and nee to eat. During an interview 5 the director of nursing (DON) be totally assisted to eat. at lunch on 1/22/15 from 11:25 R55 was being assisted to eat nade no attempt to eat	{F 3·	 2/19/2015. R55 care plan and direct dining were modified on 2/14 R58 care plan and direct dining were modified on 2/14 Shaving was provided to immediately on 1/21/2015 for of finding of hairs present or upper lip. R54 care plan for person hygiene/oral care was modif 2/14/2015. An alert was set up on 2 the PCC system to indicate fistaff when the task of shavin documented as not being do hours or more. The following message to staff on 2/16/2015: As a part of our plan of c following the recent revisit for shaving has been added to I resident as a daily task that signed off on. An alert has be trigger to the dashboard if the indicates anything other thar answer to this task. Audit that was established the initial survey will have free increased and will be ongoin "An audit of the dining experience." All nursing staff has bee the EduCare training module Cares. This module include Staff is required to complete demonstration assessment as a set of the complete demonstration assessed as a set of the complete demonstration assessed as a set of the complete demonstration assested as a set of the complete de	4/2015. tives for 4/2015. o R54 illowing report a neck and hal ied on /16/2015 in to the licensed og is one for 48 was sent out correction om the state, EVERY needs to be been set up to e CNA a yes as an ed following equency g. perience will nsure a n assigned e Personal s shaving. a skills	

Facility ID: 00705

If continuation sheet Page 13 of 22

STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245102	B. WING _			੨ 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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
{F 310}	R58 was observed a.m. and 12:00 p.n eat by NA-A. R58 's care plan p self-care deficit and assistance with ear interventions indica set up and cueing a actually fed. During an interview director of nursing to eat. R54 was observed long white facial ha and facial hair on h The quarterly Minir indicated R54 had status score of 6 w impairment, require staff with personal 9/22/13 indicated F daily living] Self Ca [related to] her den only with her ADLs "R54 is able to do I again needs to be assistant flow shee supervision with ac directed staff to as R54's facial hair or verified during an c nursing (DON) on On 1/21/15 at 2:06	on 1/22/15 between 11:35 n. R58 was being assisted to rrinted 1/22/15 indicated d that R58 needed limited ting. The care plan ated R58 needed assistant with and at times needed to be v on 1/22/15 at 4:30 p.m. the said R58 need full assistance on 1/21/15 at 1:05 p.m. with air on the left side of her neck	{F 31(All staff will be educated on the via electronic mailing, paper copy communication binder in the breat and/or through their department communication methods by 2/20 with a live in-service planned for and dietary staff members on 3/5 All nursing and dietary staff membhave completed live in-service trading knowledge of plan as stated abores and date. Compliance for adherence to this be the responsibility of the nursing department staff members with a compliance being the responsibilit Director of Nursing Services. 	v in ak room /2015 nursing /2015. bers will aining by ve by this g ve all	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/04/2015 APPROVED		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 01/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE		(X2) MULTIPLE CONSTRUCTION			COMPLETED	
245102		B. WING							
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
SAUER HEALTH CARE				1635 WEST SERVICE DRIVE WINONA, MN 55987					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
{F 310}	and R54 had not be audits process. The read, "Is able to do again needs to be s would include facial verified R54's care refused or declined removal and verified plan of care for pers On 1/22/15 at 11:25 residents were to ha removal on their ba DON stated part of plan of correction to looking for facial ha cares and completin The DON verified b R54's facial hair on expected R54 to ha removed during mo DON verified the fa- to remove facial hai Facial Hair Remova	een looked as a part of the e DON verified R54's care plan her own personal cares, but supervised" and stated this I hair removal. The DON plan did not indicate R54 assistance with facial hair d the facility did not follow the sonal hygiene for R54. 5 a.m. the DON stated ave assistance with facial hair th days and as needed. The the facility education for their o staff was they should be ir as a part of the morning ng shaving cares as needed. ased on her observation of 1/21/15 she would have twe had her facial hair crining cares yesterday. The cility failed to follow their policy ir as needed.	{F 3	10}					
{F 315} SS=D	should be shaved a tub/shower bath and between weekly bath has been completed shaving, this will be 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the fac resident who enters	male residents' facial hair as indicated weekly during her d as requested or needed thsDocument that shaving d. If a resident refuses documented as a refusal." HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the	{F 3	15}			2/19/15		

Facility ID: 00705

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				OMB NO. 0938-039		
				(X3) DATE SURVEY COMPLETED		
		A. BUILDI	NG	R		
245102		B. WING		01/22/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC		
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.		(F 31	5}			
review, the facility h comprehensive reas infection (UTI) for 1 for recurrent UTIs Findings include: R20 had a history o comprehensive reas factors (what about developed for UTIs) tract infections and interventions were o illuminate the chance A comprehensive ne 12/15/14 identified p anxiety as diagnose The quarter Minimu 12/18/14 identified I incontinence, needi toilet use and perso not identify the resid	by: Based on observation, interview and document eview, the facility had not completed a comprehensive reassessment for urinary tract infection (UTI) for 1 of 3 residents (R20) reviewed or recurrent UTIs Findings include: R20 had a history of recurrent UTIs but lacked a comprehensive reassessment to determine risk actors (what about lack of interventions leveloped for UTIs) for development of urinary ract infections and based on these assessments interventions were developed to reduce or luminate the chance of having a UTI. A comprehensive nursing assessment dated 2/15/14 identified palliative care, dysphagia, and anxiety as diagnoses for R20. The quarter Minimum Data Set (MDS) dated 2/18/14 identified R20 as having frequent incontinence, needing extensive assistance with oilet use and personal hygiene. The MDS did not identify the resident had an indwelling eatheter or a history of having UTIs.		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.			
	PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From par resident's clinical co catheterization was who is incontinent of treatment and servit infections and to res function as possible This REQUIREMEN by: Based on observat review, the facility h comprehensive reas infection (UTI) for 1 for recurrent UTIs Findings include: R20 had a history of comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about developed for UTIs) tract infections and interventions were of illuminate the chance A comprehensive reas factors (what about factors (what ab	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245102 PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	COP DEFICIENCIES OF CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULT A. BUILDI 245102 PROVIDER OR SUPPLIER HEALTH CARE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID 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. {F 31 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 were developed to reduce or illuminate the chance of having a UTI. A comprehensive nursing assessment dated 12/15/14 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.	COF DEFICIENCIES (X1) PROVIDERSUPPLIENCLA (X2) MULTIPLE CONSTRUCTION PFOORDECTION 245102 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P (163) HEALTH CARE STREET ADDRESS, CITY, STATE, 21P (163) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WINDONA, MN 55987 PROVIDER PROVIDER PROVECE DRIVE WINDONA, MN 55987 Continued From page 15 PROVIDER FOR SUPPLIER REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDENCE AND FOC (6ACH CORRECTIVE ATIO) CROSS-REFERENCED TO THE DEFICIENCY Continued From page 15 (F 315) Continued From page 15 (F 315) 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 infection as possible. In response to the above s Sauer Health Care has tak action: This REQUIREMENT is not met as evidenced by: Sauer Health Care has tak action: " An assessment titled L Infection Risk Assessment sinterventions were developed to recurrent UTIs but lacked a comprehensive reassessment of winary tract infections and based on these assessments interventions were developed to reduce or illuminate the chance of having a UTI. " An audit will be completed at a and/or with quarterly asses schedule. A comprehensive nursing assessment dated 12/15/14 identified Palliative care, dysphagia, and anxiety as		

Facility ID: 00705

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED		
		245102	B. WING			R 01/22/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	UI	22/2015	
SAUER I	HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
{F 315}	 1/22/15 at 3:30 p.m. that were checked not question/s relat no analysis of the fe determine a compre- been completed. T asked for any other comprehensive bla was provided. Review of the unda Tract Infection (UTI Management. How assess resident's ri- intervention. During an interview director of nursing s risk to develop UTI and care plans had of nursing provided comprehensive nur evaluate the reside readmission, signifi or annual review. T assessment directed bowel but did not di the resident's risk fe infection. The com assessment and re contributing factors medical conditions, 	s reviewed with the DON on a. The form only had questions yes or no. However, there was ed to having UTIs. There was orms questions marked yes to ehensive reassessment had the director of nursing was information related to a dder assessment and none ted policy procedure Urinary Prevention and ever, it did not direct staff to sk for UTIs and develop on 1/21/15 at 2:45 p.m. the she indicated all residents at s should have been assessed been developed. The director a copy of the facility ' s sing assessment used to nts on admission, cant change, quarterly review, The comprehensive nursing ed evaluation of bladder and irect or assist staff to evaluate or developing a urinary tract prehensive nursing assessment lacked or comorbidities related to cognitive function,	{F 315	5) communication binder in the breand/or through their department communication methods by 2/20 with a live in-service planned for and dietary staff members on 3/3 All nursing and dietary staff men have completed live in-service tr 3/31/2015 with others indicating knowledge of plan as stated abor same date. Compliance for adherence to thi be the responsibility of the nursin department staff members with compliance being the responsibil Director of Nursing Services.	0/2015 nursing 5/2015. hbers will raining by we by this s plan will ng overall		
{F 441} SS=E		I CONTROL, PREVENT	{F 441	1}		2/19/15	

Facility ID: 00705

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	-	AND HUMAN SERVICES			FORM	03/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245102	B. WING			R 22/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER H	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 441}	Infection Control Pr safe, sanitary and c to help prevent the of disease and infec (a) Infection Contro The facility must es Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must har transport linens so a infection.	A stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.	{F 441}			
	by:					

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		A. BUILDI	NG	R
	245102	B. WING _		01/22/2015
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
IEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETIO O THE APPROPRIATE DATE
Continued From pa	ge 18	{F 44	11}	
Based on interview failed to maintain ar that included survei trending data. This residents in the faci Findings include: On 1/22/15 a listing incidents by unit wa reading the listing it names, room numb culture reports if an resolution of infection was interviewed on stated this was the and would present to committee. The DC had been completed since the month wa were completed after However, intervention develop at the start addressed timely to determine staff edu the infection from sp DON was unable to trending of the infect requested. The designated infe- provided an antibiot and up to January 2 computer generated symptoms for which	and record review, the facility infection control program llance and analyzing and has the potential to affect all lity. of December 2014 infection s provided by the staff. On did not include resident ers, site/s of infection/s, y, staff interventions or on/s. The director of nursing 1/22/15 at 9:50 a.m. She information she would review to quality assurance DN stated that no line listing d for January 2014 at this time s not over and these listings er the month was over. ons for infections that may of the month were not prevent the spread or to cation is warranted to prevent oreading or reoccurring. The provide an analysis or etion incidence data when		In response to the abor Sauer Health Care has action: " An assessment titl Infection Risk Assessm on 2/17/2015. This ass completed on all resided having frequent or recu- identified by having mo- months or 3 in 1 year. completed by 3/31/201 " All other residents assessment completed and/or with quarterly as schedule. " An audit will be con- these are being done p schedule. " Policy titled Urinary (UTI) Identification, Tre- and Management that following the initial state reviewed and revised a to include directives to develop interventions to as well as directives or trending data for review " All staff will be edu via electronic mailing, p communication binder and/or through their de communication method with a live in-service pl and dietary staff membra All nursing and dietary	a taken the following led Urinary Tract nent was created sessment will be ents identified as urrent UTIs as ore than 2 in 6 These will be 5. will have this d at admission, ssessment mpleted to ensure ber the planned y Tract Infection eatment, Prevention was revised e survey was again on 2/17/2015 assess for risk and based on findings n analyzing and w. cated on this plan paper copy in in the break room epartment ds by 2/20/2015 anned for nursing bers on 3/5/2015. staff members will
	Continued From par Based on interview failed to maintain ar that included survei trending data. This residents in the faci Findings include: On 1/22/15 a listing incidents by unit wa reading the listing it names, room numb culture reports if an resolution of infection was interviewed on stated this was the and would present t committee. The DO had been completed since the month wa were completed afted However, intervention develop at the start addressed timely to determine staff edu the infection from si DON was unable to trending of the infection requested. The designated infection and up to January 2 computer generated symptoms for which	IDENTIFICATION NUMBER: 245102 PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	OF DEFICIENCIES (F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 245102 B. WING PROVIDER OR SUPPLIER 245102 B. WING FEALTH CARE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFID TAG 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. [F 44 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 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	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/LIA IDENTIFICATION NUMBER: 245102 (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER 245102 STREET ADDRESS, CITY, STATE 1633 WEST SERVICE DRIVE WINDAA, MN 55987 FEALTH CARE STREET ADDRESS, CITY, STATE 1633 WEST SERVICE DRIVE WINDAA, MN 55987 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 18 [F 441] 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. [F 441] Findings include: In response to the abc Sauer Health Care has action: " An assessment tit Infection Risk Assesson on 2/17/2015. This as completed 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 22 14 at this time since the month was not over and these listings were completed after the month was over. DON was unable to provide an analysis or trending of the infection incidence data when requested. " An audit will be cdu via electronic mailing , communication binder" All staff will be edu via electronic mailing , communication binder" All

Facility ID: 00705

	AS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245102	B. WING _			R 01/22/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
SAUER HEALTH CARE				1635 WEST SERVICE DRIVE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
{F 441}	of nursing was inter a.m. She stated no laboratory test for in member had tested director recommen- used for a preventar residents. During the residents identified had pneumonia/rest influenza testing wat 1/22/15 RN-A state have confirmed cast radiology results compared to the state of the rest of the state of the s	age 19 en for influenza). The director rviewed on 1/22/15 at 9:50 o resident had a positive influenza, but that a staff d positive so at the medical ded the Tamiflu should be ative measure for the his same time period three on the antibiotic line listing spiratory infections and no as noted. At 12:40 p.m. on d these three residents did not ses of pneumonia since no onfirmed them. The residents with antibiotics just to be safe.	{F 44	 1} Compliance for adherence to the the responsibility of the nurdepartment staff members and infection control nurse with over provided by the QA team and compliance being the respons Director of Nursing Services. Additional actions taken not refindings listed in the citation. Following exit of the state team much internal investigation place to identify root cause of issues, identify risk factors and strategically plan ways for add prevention. The infection control nurse a review of UTI incidence datin 2013. This review did identify a prevention. A team consisting of three members completed a review reported data. The facility determined that be in the best interests of the rest interest is any correlation in thes is the rest interest is any correlation in the set interest is any correlation in the set interest is the facility of the rest is any correlation in the set interest is any correlation in the set interest is any correlation in the set is any correlation in the set is any correlation in the set is any correlation is the set is any correlation in the set is any correlation in the set is any correlation in the set is any correlation i	sing d the ersight overall ibility of the lated to the survey on took current UTI d ed e completed ng back to possible ear of 2013 vitch in ucts at that RN staff of the at it would residents to ain to see if e findings. rofessional 2/17/2015		

Facility ID: 00705

If continuation sheet Page 20 of 22

		AND HUMAN SERVICES			FORM	03/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		245102	B. WING			י 22/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER I	HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
{F 441}	Continued From pa	age 20	{F 44	 41} o The infection control nurse of research on prophylactic UTI mand found information on UTI S was shared with the Medical Dir ? He does not wish to implem process at this time but instead review the success or failure rest from the above mentioned prod ? Medical Director also spent considerable time educating the members on the importance of differentiating between urinary to infections that require treatment asymptomatic bacteremia and/c colonized bacteria. " This information has been at the above mentioned policy. o The current infection issues shared with the Clinical and Reg Compliance Nurse at Profession Medical and she offered some i via email that is being reviewed. ? Many of her suggested active already in place at the facility buinformation will be kept as a refe use as needed following finding product change that is currently implemented. o The DON and Maintenance reviewed the current disinfectant being used on shared facility ite as commodes, shower chairs efficient as a result of nursing staff has been assigned EduCare training module Perso This module includes perineal c females & males as well as toile 	ethods tat that ector. ent this wait to sulting uct switch. • QA team ract and or added to were gulatory nal nformation ons are it this erence to s from being Director t products ms such ic idered as the this, all the nal Cares. are for	

Event ID:27LG12

Facility ID: 00705

If continuation sheet Page 21 of 22

T OF DEFICIENCIES		-). 0938-0391
OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
	245102			01	R / 22/2015
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		/22/2010
HEALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
			41} is required to complete a s demonstration assessmen	kills t and all will	
	(EACH DEFICIENC REGULATORY OR L	HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP HEALTH CARE 1635 WEST SERVICE DRIVE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID Provider of the preceded of	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE 1635 WEST SERVICE DRIVE 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)

Facility ID: 00705

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 245102	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 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	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix		Completed 01/04/2015	ID Prefix		Completed 01/04/2015	ID Prefix		Completed 01/04/2015
Reg. #	NFPA 101		Reg. #	NFPA 101		Reg. #	NFPA 101	
LSC	K0029	_	LSC	K0033	-	LSC	K0062	
		Correction Completed			Correction Completed	ID Profix		Correction Completed
					-			
Reg. # LSC			Reg. # LSC			Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			Reg. #					
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:		Date	:
State Agen	cy PS/KH	D	01/29/201	5	2582	22		01/05/2015
Reviewed E CMS RO	3y Reviewe		Date:	Signature of Sur	rveyor:		Date	::
Followup t	o Survey Completed of 11/19/2014	on:		Check for any Unco Uncorrected Defic				S 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.

Sauer Health Care February 10, 2015 Page 2

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 <u>gary.nederhoff@state.mn.us</u> 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.

Sauer Health Care February 10, 2015 Page 3

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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 00705	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/22/2015
Name	e of Facility		Street Address, City, State, Zip Code	
SA	UER 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	(Y4) Item		(Y5) Date	(Y4) Item	(Y	5) Date	
		Correction Completed	d		Correction Completed			Con	rection npleted
ID Prefix		01/04/201	5 ID Prefix	20540	01/04/2015	ID Prefix			04/2015
		8.0100 Subp.		MN Rule 4658.			MN Rule 4658.0		
	MN Rule 465	Correction Completer 01/04/201 8.0405 Subp.	d ID Prefix Reg. #	20850 MN Rule 4658.		Reg. #	_20860 MN Rule 4658.0	Con 01/0 0520 Subp. :	rection npleted 04/2015
ID Prefix Reg. # LSC	MN Rule 465	Correction Complete 01/22/201 8.0610 Subp.	d ID Prefix Reg. #	21426 MN St. Statute		Reg. #	21830 MN St. Statute	Con 01/0 144.651 Sul	rection npleted 04/2015
ID Prefix Reg. # LSC	-	Correction Complete 01/04/201 te 144.651 Sul	d			ID Prefix Reg. # LSC		Con	rection npleted
ID Prefix Reg. # LSC		Correction Completed				ID Prefix Reg. # LSC		Con	rection npleted
Reviewed I State Agen	cy	Reviewed By GPN/kfd	Date: 03/24/10)15		31221			/2015
	to Survey Con 11/2	Reviewed By mpleted on: 5/2014 REPORT (5/99)	Date:	Check for a	re of Surveyor: ny Uncorrected Defic ted Deficiencies (CM		a Summary of the Facility?	Date: YES NO LG12)

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00705	B. WING		F 01/2	२ २/२०१५
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAUER H	IEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	January 21 & 22, 20 was determined the have not been corre- licensing survey. Th remain in effect and onsite visit. Also ur	TS: visit was completed on 015. During this onsite visit it ere are licensing orders that ected at the time of this nese uncorrected order/s will d will be reviewed at the next ncorrected order/s will be				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	PER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/19/15

Electronically Signed

STATE FORM

If continuation sheet 1 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING	·····		R
		00705	B. WING			22/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SAUER H	IEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 000}	Continued From pa	ige 1	{2 000}			
	reviewed for possib	le penalty assessment/s.				
{2 565}	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	{2 565}			
		omprehensive plan of care I personnel involved in the t.				
	by: This licensing order Based on observati review the facility fa care plan which wa comprehensive ass (R46, R62, R55, R5 with eating; the faci care plan for 1 of 1 change in health sta been contacted tim follow 1 of 3 resider personal hygiene no Findings include:		3			
	the care plan: R46, R62, R55, R5 11:05 a.m. to 12:00	ating assistance as directed in 8 observed on 1/22/15 from p.m. seated at a table dents who needed staff ieir meals.				
	R46 was observed	from 11:10 a.m. to 12:00 p.m.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00705	B. WING			R 01/22/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
SAUER I	HEALTH CARE		ST SERVICE I MN 55987	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 565}	 wheelchair while R uncovered. No sta assist her with eatin was observed to ke away from the table assistant would put staff stood to encor her with cutting the of the meal. The care plan print deficit. The care pl feed herself, but pe assistance to open dining room were r also indicated staff eat. During an interview director of nursing cued for eating. Th to take a fork to he have food on the for 	to be sleeping in the 46's food sat in front of her ff was sitting beside her to ng or to cue her to eat. R46 eep pushing the wheelchair e and the nurse or nursing sh her back to the table. One urage her to eat and assisted food. R36 ate less than 25% ed 1/22/15 identified self-care lan indicated R46 was able to erhaps needed some things, but most items in the eady to eat. The care plan was to be there to help R46 <i>r</i> at 4:30 p.m. on 1/22/15 the (DON) stated R46 was to be the DON stated R46 was able r mouth, but did not always ork. DON stated NA-A should eat and that it would be okay to	{2 565}				
	1/22/15 from 11:05 no attempt to feed resident to eat. NA provide guidance fo	during the lunch meal on a.m. to 12:00 p.m. R62 made self. NA-A assisted the A-A was not observed to or eating safely or encouraged one point NA-A left R62 and R62 food.					
	at a potential for nu provided meals at t The care plan direct	ed 1/22/15 indicated R62 was utritional risk and was to be the restorative dining table. cted staff were to encourage o tuck chin, to sit at 90					

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00705	B. WING			R 01/22/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
SAUER I	HEALTH CARE		ST SERVICE I	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 565}	Continued From pa	age 3	{2 565}				
	double swallow. In	age through clearing and another area of the care plan oted R62 was totally to eat.					
	director of nursing totally assisted to e	v at 4:30 p.m. 1/22/15 the (DON) stated R62 was to be eat. The DON stated R62 ed at the restorative table if t independently.					
		at lunch on 1/22/15 from 11:2 R55 was being fed by NA-A npt to feed herself.	5				
	on the restorative r eating/swallowing. promote independen needed for task co the care plan identi deficit and indicate assistance for eatin eating process. Th	ed 1/22/15 indicated R55 was nursing program for Staff was to provide cueing to ent eating and assistance as mpletion. In another area of ified a problem of self-care d R55 needed extensive ng and help with the actual ne care plan also directed R55 ment to eat and needed to be					
		v at 4:30 p.m. 1/22/15 the stated R55 was to be cued for					
		during the noon meal on 1:35 a.m. and 12:00 N. R58 IA-A.					
	deficit and that R58 with eating. The ca	ed 1/22/15 indicated self-care 3 needed limited assistance are plan interventions indicated ant with set up and cueing and be actually fed.					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED R
		00705	B. WING	B. WING		22/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE I , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{2 565}	Continued From pa	ge 4	{2 565}			
	NA-A stated only or help at the restorati R62 would never fe advanced dementia help. NA-A stated I feed self but neede During an interview director of nursing (one staff member v restorative table wh that need a restorati stated she did not k assist During an interview director of nursing i fed. DON stated R and had a restorative to set-up the meal f and provided hand needed. DON stated the facility hoped w needed to be updat Lack of timely notifi R14's interdisciplina dated 1/19/15 at 6: shortness of breath chest pain and state	cation of change in condition: ary team (IDT) progress notes 17 p.m. said R14 experienced , sweating, and complained of				
	(anti-anxiety medica 6:40 p.m. and 7:50 Duonebs (respirato as needed morphin	red as needed Lorazepam ation), three times between p.m. on 1/19/15; as needed ry medication) one time; and e (narcotic pain medication) p.m. and 9:30 p.m. Further				

Minneso	ota Department of He	alth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING			R 22/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1635 WE	ST SERVICE I	DRIVE		
SAUER	HEALTH CARE	WINONA	, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{2 565}	Continued From pa	ge 5	{2 565}			
	review of the MAR received as needed Duonebs at any oth to January 22, 2015 The IDT progress r and it read a nurse sounds, but had no practitioner or hosp deterioration of hea interdisciplinary pro- through 1/21/15 did physician (MD), nur hospice nurse. R14's care plan prin myocardial infarction artery disease (CAI staff to monitor/doc practitioner or medi symptoms of CAD, shortness of breath hospice form direct condition, hospice s notified. The direct interviewed on 1/22 she was unaware of check with the LPN evening. At 12:52 p should have complet the medications and (TMA) to give the a DON verified the do that an assessmen medications were g DON stated she did nurse on duty that even interview a directed	indicated R14 had not morphine, Lorazepam or ter time from January 1, 2015 tote dated 1/19/15 at 6:17 p.m. had assessed lung and heart t notified the physician, nurse				

	NT OF DEFICIENCIES	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00705		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 01/22/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER	HEALTH CARE	1635 WE	ST SERVICE I , MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{2 565}	policy read, "The at physician/NP on ca in a resident's conc policy also identified breath and chest pa that were to be repa also directed the ch to be notified. Lack of providing n plan: R54 was observed long white facial ha and facial hair on h The quarterly Minin indicated R54 had a status score of 6 w impairment, require staff with personal 9/22/13 indicated R daily living] Self Ca [related to] her dem only with her ADLs. is able to do her ow needs to be superv flow sheet indicated with activities of da assist with hair care R54's facial hair on verified during an o nursing (DON) on 1 On 1/21/15 at 2:06 care plan read, "Is cares, but again ne stated this would in	 1/11/14 was reviewed. The ttending physician or all will be notified with changes lition or health status "The d symptoms of shortness of ain as changes in condition orted. The policy procedure harge nurse or supervisor was ail care as directed on the care on 1/21/15 at 1:05 p.m. with ir on the left side of her neck er upper lip. In the left side of her neck er upper lip. In the left sisten of one hygiene. The care plan dated assistance of one hygiene. The care plan dated as had, an "ADL [activity of re Performance Deficit r/t nentia. She needs supervision "Interventions included, "R54 <i>in</i> personal cares, but again tised." The nursing assistant d R54 required supervision ily living and directed staff to e/grooming. her neck and upper lip was bservation by the director of 1/21/15 at 2:02 p.m. p.m. the DON verified R54's able to do her own personal eares and clude facial hair removal. The care is and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " and clude facial hair removal. The care is a supervised " a supervised " and clude facial hair removal. The care is a s				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING			R 22/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER H	IEALTH CARE		ST SERVICE I , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 565}	Continued From pa	ge 7	{2 565}			
	will be reviewed at	rder/s will remain in effect and the next onsite visit. Also s will be reviewed for possible t/s.				
{2 910}	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	{2 910}			
	have a continuous p management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident wh receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ig catheter is not catheterized 's clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to it infections and to restore as er function as possible.				
	by: This licensing order	ent is not met as evidenced r was not corrected due to:				
	review, the facility h comprehensive rea	on, interview and document had not completed a ssessment for urinary tract of 3 residents (R20) reviewed				
	Findings include:					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00705	B. WING			R 01/22/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SAUER I	HEALTH CARE		ST SERVICE I	DRIVE			
	1		, MN 55987		0000000101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 910}	Continued From pa	age 8	{2 910}				
	comprehensive rea factors (what about developed for UTIs tract infections and interventions were illuminate the chan A comprehensive r 12/15/14 identified anxiety as diagnos The quarter Minimu 12/18/14 identified incontinence, need toilet use and persent not identify the resis catheter or a histor The director of nur R20's comprehens 12/15/14. This was 1/22/15 at 3:30 p.m that were checked not question/s relation that were checked not question/s relation analysis of the f determine a comprise been completed. The asked for any othe comprehensive blation was provided. Review of the undata Tract Infection (UT Management. How	um Data Set (MDS) dated R20 as having frequent ling extensive assistance with onal hygiene. The MDS did ident had an indwelling ry of having UTIs. sing (DON) provided a copy of sive nursing assessment dated s reviewed with the DON on n. The form only had questions yes or no. However, there was ted to having UTIs. There was forms questions marked yes to rehensive reassessment had The director of nursing was r information related to a adder assessment and none	5				
		v on 1/21/15 at 2:45 p.m. the she indicated all residents at					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED R
		00705	B. WING			22/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE E , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 910}	and care plans had of nursing provided comprehensive nur evaluate the reside readmission, signifi or annual review. T assessment directe bowel but did not di the resident's risk for infection. The com assessment and re contributing factors medical conditions, medications, physic environment.	s should have been assessed been developed. The director a copy of the facility ' s sing assessment used to nts on admission, cant change, quarterly review, The comprehensive nursing ed evaluation of bladder and rect or assist staff to evaluate or developing a urinary tract nprehensive nursing assessment lacked or comorbidities related to cognitive function,				
{21390}	penalty assessmen MN Rule 4658.0800	0 Subp. 4 A-I Infection Control	{21390}			
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident h	and procedures. The infection ust include policies and provide for the following: based on systematic data v nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00705			COM	e survey Pleted R 22/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21390}	the prevention and F. the development employee health por practices, including defined in part 4658 G. a system for products which affed disinfectants, antise incontinence product I. methods for for current standards of This MN Requirement by: This licensing order Based on interview failed to maintain at that included surveit trending data. This residents in the fact Findings include: On 1/22/15 a listing incidents by unit wa reading the listing it names, room numb culture reports if an resolution of infection was interviewed on stated this was the and would present for had been complete	ent care practices to assist in treatment of infections; nent and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of f practice in infection control. ent is not met as evidenced r was not corrected due to: and record review, the facility n infection control program llance and analyzing and has the potential to affect all	{21390}			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		00705	B. WING		01/	22/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SAUER I	IEALTH CARE		ST SERVICE D A, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{21390}	Continued From pa	ge 11 ons for infections that may	{21390}			
	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.					
	provided an antibio and up to January 2 computer generate symptoms for which	ection control nurse (RN)-A tic listing for December 2014 22, 2015. This listing was d and did not indicate h the antibiotics were given, rventions or resolutions of				
	The antibiotic listing 22, 2015 noted the (antiviral agent give of nursing was inter a.m. She stated no laboratory test for in member had tested	g from January 1 to January entire facility received Tamiflu en for influenza). The director rviewed on 1/22/15 at 9:50 o resident had a positive influenza, but that a staff I positive so at the medical dead the Tamifly aboutd be				
	used for a preventa residents. During t residents identified had pneumonia/res influenza testing wa 1/22/15 RN-A state have confirmed cas radiology results co	ded the Tamiflu should be ative measure for the his same time period three on the antibiotic line listing piratory infections and no as noted. At 12:40 p.m. on d these three residents did not ses of pneumonia since no onfirmed them. The residents				
	This uncorrected of will be reviewed at	with antibiotics just to be safe. rder/s will remain in effect and the next onsite visit. Also s will be reviewed for possible t/s.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED R
		00705	B. WING			22/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER H	HEALTH CARE		ST SERVICE I	DRIVE		
(,)		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{21805}	Continued From pa	ige 12	{21805}			
{21805}	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	{21805}			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by:	ent is not met as evidenced r was not corrected due to:				
	review the facility fa dining service for 4	ion, interview and document ailed to provide a dignified of 20 residents (R46, R62, erved during the dining				
	Findings include:					
	staff for eating assi timely and consiste	8 who were dependent on stance were not provided int assistance to ensure a perience for each resident was				
	table with R46, R62 a.m. NA-A was obs attempted to feed s remained seated w	NA)-A was observed sitting at 2, R55, and R58. At 11:44 erved to leave the table R46 self while the other residents ith no attempt to feed self was sitting in front of them. A	t			
	11:47 NA-A returne and set up drinks for walked around the R46 to assist them R62 remained sittin	d to sit between R62 and R55 or them, then NA-A got up and table to sit between R58 and to eat. At 12:03 p.m. R55 and ng at the table not eating or by staff to eat the meal. NA-A	1			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00705		- B. WING			R 22/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE I	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{21805}	assisted R46 to pla p.m. R55 was observed to move to observed to move to assist them to eat a cued to eat for the p warmed the meal for to assist them to eat NA-A was interview NA-A stated only or help at the restoration included R58, R46, that R62 would new had advanced dem needed help. NA-A able to feed self but so. During an intervithe director of nursion only one staff mem residents at the rest have only residents program. DON stato other staff did not a help. R46 did not received during the meal ser- dining experience. a.m. to 12:00 p.m. wheelchair while a her at the table. No assist her with eatir was observed to ket away from the table assistant would pus	ce food on the fork. At 12:08 erved not to eat and was not or assisted to eat. At 12:12 bing at the table and had not o eat. At 12:14 p.m. NA-A was between R58 and R55 to as they had not been helped or past 24 minutes. NA-A had not or R58 and R55 before starting				

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	00705		B. WING			R 01/22/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	HEALTH CARE	1635 WE	ST SERVICE	DRIVE			
SAULNI		WINONA	, MN 55987				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{21805}	Continued From pa	age 14	{21805}				
	self-care deficit and	nted 1/22/15 identified d indicated R46 was able to erhaps needed some					
		at 4:30 p.m. on 1/22/15 the (DON) stated R46 was to be					
	during the meal set dining experience. lunch meal on 1/22 p.m. R62 made no For a short time NA and then left R62 to	e the assistance she needed rvice to promote a dignified R62 was observed during the 2/15 from 11:05 a.m. to 12:00 o attempt to eat independently. A-A assisted the resident to eat o help another resident then s observed to cut R62 food.					
	was to be provided	nted 1/22/15 indicated R62 meals at the restorative dining were to encourage the	3				
		v at 4:30 p.m. 1/22/15 the (DON) stated R62 was to be eat.					
	during the meal set dining experience. on 1/22/15 from 11 made no attempt to cueing and NA-A a	e the assistance she needed rvice to promote a dignified R55 was observed at lunch :25 am to 12:00 p.m. and p eat independently or with ssisted her intermittently while th between two residents.					
	was on the restorat eating/swallowing.	rinted 1/22/15 indicated R55 tive nursing program for Staff was to provide cueing to ent eating and assistance as					

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00705	B. WING			R 22/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	IEALTH CARE		ST SERVICE D	DRIVE		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				N OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
{21805}	Continued From pa	age 15	{21805}			
	the care plan identi	mpletion. In another area of fied a problem of self-care d R55 needed extensive ng				
		at 4:30 p.m. 1/22/15 the stated R55 was to be cued for				
	during the meal set dining experience. noon meal on 1/22, 12:00 p.m. and rec	e the assistance she needed rvice to promote a dignified R58 was observed during the /15 between 11:35 a.m. and eived intermittent assistance was helping several residents rvice.				
		nted 1/22/15 indicated d that R58 needed limited ing.				
	director of nursing assisted to eat. DO restorative table an program. Also DO the meal for R58, p	on 1/22/15 at 4:30 p.m. the indicated R58 was to be totally DN stated R58 sat at the id had a restorative dining N said that staff was to set-up provide verbal cues, and r hand assistance as needed.	,			
	will be reviewed at	rder/s will remain in effect and the next onsite visit. Also s will be reviewed for possible tt/s.				

DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES	
					AND TRANSMITTAL TE SURVEY AGENCY	ID: 27LG	
1. MEDICARE/MEDICAID PROVIDE					LE SURVET AGENCT	Facility ID: 00705 4. TYPE OF ACTION: 2 (L8)	
1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS (L1) 245102 (L3) SAUER HEALTH (4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID NO	(L4) 1635 WEST SERVICE DRIVE			1. Initial2. Recertification3. Termination4. CHOW			
(L2) 493543800	(L5) WINONA, N	MN		(L6) 55987	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint	
(L9) 6. DATE OF SURVEY 11/25/2	2014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA		
 8. ACCREDITATION STATUS: 	(L10)	02 SNF/NF/Duai 03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Other							
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY A. In Complia		AS:	And/Or Approved Waivers Of	The Following Requirements:	
From (a) : To (b) :		-	equirements		2. Technical Personnel	6. Scope of Services Limit	
	= 1 (110)	^	e Based On:		3. 24 Hour RN	7. Medical Director	
12. Total Facility Beds	71 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	 F)8. Patient Room Size 9. Beds/Room 	
13.Total Certified Beds	71 (L17)	X B. Not in Cor Requirem	npliance with Prog ents and/or Appli		* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN	1			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
71							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Gail Sorensen, HFE NI	T T	()1/06/2015				
				(L1))	č	Enforcement Specialist 01/07/2015 (L20)	
PAR	T II - TO BE	COMPLETED	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILI	ТҮ		IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 		
1. Facility is Eligible to Pa	rticipate	140			3. Both of the Above		
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	AENIT 2	4. LTC AGREEN	AENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING		4. LIC AGREEN		voluntary <u>00</u>		
01/19/1967	DEGITITIT	DITL	ENDING DA	IL	01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPE	ROVAL	



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 <u>Kathryn.serie@state.mn.us</u> 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. Sauer Health Care December 15, 2014 Page 4

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

Sauer Health Care December 15, 2014 Page 5

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 Sauer Health Care December 15, 2014 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

					. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		E SURVEY IPLETED
	ROVIDER OR SUPPLIER	245102	B. WING	TTREET ADDRESS, CITY, STATE, ZIP CODE	/25/201 <u>4</u>
				1635 WEST SERVICE DRIVE	
SAUER H	IEALTH CARE		v	WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 000		
	as your allegation of Department's acce enrolled in ePOC, at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 166 SS=E	on-site revisit of yo validate that substa regulations has be your verification.	acceptable electronic POC, ar ur facility may be conducted to antial compliance with the en attained in accordance with T TO PROMPT EFFORTS TO ANCES			1/4/15
	facility to resolve g	right to prompt efforts by the rievances the resident may se with respect to the behavior			
	by: Based on observa review, the facility f complaints timely f	NT is not met as evidenced tion, interview, and document failed to address cool room or 1 of 6 residents (R24) nple on west wing with cold		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.	
	Findings include:			In response to the above stated citation Sauer Health Care has taken the following action:	3
	During interview or the room was cold cold room to staff.	cold room temperatures. 11/18/14, at 8:58 a.m., stated R24 stated had reported the Observations at that time d was positioned by the		 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 	

Electronically Signed

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.

	-	H AND HUMAN SERVICES				APPROVE 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED	
	\mathbf{D}	245102	B. WING	FIN		25/201 <u>4</u>
JAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD	E	
SAUER I	HEALTH CARE			1635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 166	Continued From	page 1	F 166			
	covered with a sw During environme p.m., director of e verified the cold r spot checked roo was a complaint. had cold tempera which he repaired cold room compla Document review policy dated 10/1, "There is adequa	in a wheelchair and R24 was weater and blanket. ent tour on 11/20/14, at 1:30 environmental services (DES-A) ooms for R24. DES-A stated he m temperatures only if there He stated last week the facility ture complaints on east wing d. He stated he was not aware of aints on west wing. of facility physical environment /09-patient environment: #2. te heating system to maintain beratures of at least 71 degrees g system."		 window. Maintenance Director visit residents including (R24) on 1 and did follow up visits on 11/2 11/21/2014. Follow up visits of resident satisfaction with overa in building temperature. The policy titled, Grievance dated 2/4/2014 was reviewed be up to date, no changes were The policy titled, Physical Environment dated 10/1/2009 reviewed and felt to be up to de changes were made. A note stating the following encourage resident/family to be concerns/complaints to facility residents have the right to pro by the facility to resolve grieval resident may have, including the respect to the behavior of other will be included in the January the facility newsletter. Social Services Director m (R24) on 12/16/2014 related to temperature of her room, to try ascertain who she expressed in the past re: her room. And her she can bring any concern staff and if they don t get reso she should contact a manager On 11/26/2014 the following was sent to the nursing staff fr DON via email as a reminder a introduction of the education p the need to be aware of the re overall comfort level including temperature in the facility. Please be asking the resident of the resolution of the reso	1/19/2014 & concluded all increase e Policy and felt to re made. was late, no g, We oring r staff and mpt efforts nces the hose with er residents redition of net with o the y to concern to to remind ns to any olved that r. ng memo rom the and olanned on sidents the	

Facility ID: 00705

If continuation sheet Page 2 of 39
STATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	245102		B. WING	ETN	11/25/2014	
	PROVIDER OR SUPPLI		S	TREET ADDRESS, CITY, STATE, ZIP CODI		23/2014
	JER HEALTH CARE			635 WEST SERVICE DRIVE		
SAUER I	IEALTH CARE			VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	Continued From	page 2	F 166	their comfort level when you and with them and this includes be or too cold in their home. If yo cold in a certain area of the face mention it so we can look into concern can be addressed, off resident additional blankets if t cold. "Sauer Health Care board of approved on 9/15/2014 the put an automatic temperature con- monitoring system for the entir Maintenance has begun the pr getting this system installed. "Maintenance staff when no complaint or concern will comp monitoring of the area indicate complaint or concern with use portable thermostat to ensure temperature is within the recor guidelines and take actions as problems are identified. "Administrator attended res council on 12/2/2014 and revie citations including this one and residents to report any concern temperature to the staff, includ Administrator if need be. "Education was provided to in-service training on 12/11/20 will be trained on all plan of ca information by 1/4/2015. "Citation and plan for correct	ing too hot u feel it is cility please it. Until the er the hey are too of directors rchase of trol e building. ocess of otified of a olete a d in the of a the nmended needed as ident ewed I reminded ns about the ing the staff at an 14. All staff re	
				and ongoing prevention to be r QA meeting on 1/13/2015. Compliance for adherence to t be the responsibility of all Saud Care staff with overall complia	eviewed at his plan will er Health	

Event ID: 27LG11

Facility ID: 00705

If continuation sheet Page 3 of 39

CENTER STATEMENT	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	: 01/06/2015 APPROVED . 0938-0391 E SURVEY IPLETED
	245102 ROVIDER OR SUPPLIER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	25/201 <u>4</u>
(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 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.	F 241	Mainenanoo Doparanon managon	1/4/15
	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		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	

Facility ID: 00705

If continuation sheet Page 4 of 39

CENTER STATEMENT	MENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	01/06/2015 APPROVED 0938-0391 E SURVEY PLETED
	245102 PROVIDER OR SUPPLIER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	25/201 <u>4</u>
(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 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.	

If continuation sheet Page 5 of 39

STATEMENT	OF DEFICIENCIES OF CORRECTION	XE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIE	245102 R	B. WING	REET ADDRESS, CITY, STATE, ZIP COE	11/25/201 <u>4</u>
SAUER	HEALTH CARE			35 WEST SERVICE DRIVE NONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO
F 241	Continued From eating or drinking		F 241		
	the potential to be advanced dement therapeutic diet a diet consistency p well as varying in Interventions: En- and then assist w not feed herself care plan dated 9 [activity of daily lin Deficit r/t [related decreased function requiring staff asses Interventions:ru one staff with her encouragement to to be fed (total) a to do with the silv days." The quarter assessment date required extensive nutritional assesses "FEEDING: Abl assisted in the dir During an intervise director of nursing seated next to rea assisting them to verified it was a do resident and assis The Feeding a Du 11/6/13 read, "6. going to be seated	care dated 8/22/14 read, "has e at nutritional risk d/t [due to] tia m/b [may be] need for is well as mechanically altered ber MD [medical doctor] order as takes for all meals courage [R37] to feed herself, <i>i</i> th feeding when resident does " The activity of daily living 0/19/14 read, " has an ADL ving] Self Care Performance to] impaired cognition and onal status m/b [may be] sistance with all ADLs equires extensive assistance of meals. She needs o eat and will sometimes need s she seems not to know what rerware on certain, less aware, erly Minimum Data Set (MDS) d 10/28/14 indicated R37 re assist of 1 staff for eating. The sment dated 6/25/14 read, to feed herself Summaryis ning room with meals." ew on 11/20/14 at 2:34 p.m., the g stated she expected staff to be sidents in the dining room when eat their meals. The DON lignity issue to stand by a st them to eat their meal.			

If continuation sheet Page 6 of 39

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) DAT	0. 0938-039 TE SURVEY MPLETED
245102			TREET ADDRESS, CITY, STATE, ZIP CODE	/25/201 <u>4</u>
IEALTH CARE		v	VINONA, MN 55987	
(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
		F 241		
483.15(b) SELF-	DETERMINATION - RIGHT TO	F 242		1/4/15
schedules, and h her interests, ass interact with mer inside and outsid about aspects of	health care consistent with his or sessments, and plans of care; nbers of the community both le the facility; and make choices his or her life in the facility that			
by: Based on intervi facility failed to p	ew and document review, the rovide choices regarding bathing		action: " On 11/26/2014 the following memo	3
R70's annual Mir 10/9/14, identifie Aphasia (unable cerebrovascular	nimum Data Set (MDS) dated d but not limited to diagnoses of to communicate accurately), accident, atrial fibrillation and		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	
person physical a mental status (B moderate cogniti	assist. R70's brief interview for IMS) score of twelve indicated ve impairment.		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	
" has an actual CVA [cerebrovas hemiplegiaInte	self-care deficit as related to his cular accident] with right sided erventionsneeds the extensive		 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 	
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIE IEALTH CARE SUMMARY S (EACH DEFICIEN REGULATORY O Continued From both them and th 483.15(b) SELF- MAKE CHOICES The resident has schedules, and h her interests, ass interact with men inside and outsid about aspects of are significant to This REQUIREM by: Based on intervi facility failed to p frequency for 1 o choices. Findings Include: R70's annual Mir 10/9/14, identifie Aphasia (unable cerebrovascular required physical mental status (Bl moderate cogniti R70's plan of car " has an actual CVA [cerebrovas hemiplegiaInter assistance of one	F CORRECTION IDENTIFICATION NUMBER: 245102 PROVIDER OR SUPPLIER IEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 both them and the resident." 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 barie 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 hemiplegiaInterventionsneeds the extensive assistance of one for bathing. He may be able to	OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING ROVIDER OR SUPPLIER 245102 B. WING IEALTH CARE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 6 both them and the resident." F 241 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. F 242 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 hemiplegiaInterventionsneeds the extensive	OP DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLICE(LAL DENTIFICATION NUMBER: (X2) MLITFLE CONSTRUCTION (X3) DAT A BUILDING IFALTH CARE 245102 B. WING TEELT HORESS, CITY, STATE, ZP CODE 11/ STREET ADDRESS, CITY, STATE, ZP CODE IEALTH CARE ID REQUIDER OR SUPPLIER ID REQUIDER OF SUPPLIER ID REGUIDER OF SUPPLIER OF SUPPLIER OF SUPPLIER ID REGUIDER OF SUPPLIER OF SUPPLIER ID REGUIDER OF SUPPLIER OF SUPPLIER

Facility ID: 00705

If continuation sheet Page 7 of 39

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES		0	-	APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245102	B. WING		11/2	5/2014
	PROVIDER OR SUPPLIEF	R	s	TREET ADDRESS, CITY, STATE, ZIP CODE	-	<u>.</u>
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 242	Continued From p	bage 7	F 242			
	p.m., when asked times a week you responded, " No! finger to answer h a shower or a bat more than one sh shook his head in would like three b When asked if he more than one sh shook his head you During an intervie registered nurse (the facility for bath resident requested physician order sp RN-B stated the b	w on 11/21/14, at 11:18 a.m., (RN)-B stated it was standard in hing one time a week unless a d additional baths or we have a pecifying bathing frequency. bathing schedule was based on		twice weekly bathing. " On 11/28/2014 a CNA staff me completed an audit of all current re to address bathing preferences. All current residents who are able to e their wishes were asked about bath preference and the current bathing schedule was reviewed. The resid were then asked if they were satisf the frequency and time of their cur schedule and the bathing schedule adjusted accordingly for any reside expressed dissatisfaction. " The current Comprehensive N Assessment in use was modified of 12/10/2014 to include a section rel resident preferences. This section now include asking questions about bathing preferences. Resident batt will then be completed based on the indications.	esidents l express hing lents ried with rent e was ent who ursing on ated to will ut hing lese	
	or preference bas RN-B stated wher admission, I let th on a specific day. about our bathing are provided one bathing twice a da residents they jus would like addition will accommodate spoke with R70 re bathing frequency bathing two times conversation.	ess there was a specific request eed on evening or morning. I visit with residents upon em know their shower or bath is RN-B stated I instruct residents process informing them baths time a week, with sponge ay. RN-B stated I inform t need to let staff know if they hal baths and stated the facility e requests. RN-B stated she egarding his preference for v and R70 will be scheduled for per week per their		 Administrator attended resider council on 12/2/2014 reviewed cita with residents and encouraged resident to notify Administrator of any concern that staff do not address. Education was provided to station-service training on 12/11/2014. will be trained on all plan of care information by 1/4/2015. Citation and plan for corrective and ongoing prevention to be revie QA meeting on 1/13/2015. Compliance for adherence to this probe the responsibility of the RN unit managers and the licensed staff as as certified nursing assistants with 	tions idents erns ff at an All staff e action ewed at blan will s well	

Facility ID: 00705

If continuation sheet Page 8 of 39

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING _		E SURVEY IPLETED
IAME OF F	245102 PROVIDER OR SUPPLIER	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	25/201 <u>4</u>
SAUER H	IEALTH CARE		635 WEST SERVICE DRIVE /INONA, 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) COMPLETIC DATE
F 242	Continued From page 8	F 242		
	not provided.		compliance being the responsibility of the Director of Nursing Services.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		1/4/15
	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.			

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CENTE	IMENT OF HEALTH AND HUM				PRINTED: 01/06/2015 FORM APPROVED OMB NO. 0938-0391
		ER/SUPPLIER/CLIA ICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		245102	B. WING		11/25/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PR REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 272	Continued From page 9		F 272		
	This REQUIREMENT is not m by: Based on interview and docur facility failed to complete a cor assessment to determine inter insomnia for 1 of 1 resident (R facility with a diagnosis of inso a sleep medication. Findings include: R91 was not comprehensively insomnia according to the Mini requirements for all residents a facility. R91 was admitted to the facilitt diagnoses as listed on the phy acute kidney failure, diabetes, depression, and insomnia. Th assessment) text note dated 1 R91 had a BIMS (brief intervie status) of 8 out of 15 or moder PHQ-9 score of 1 indicating m and included a diagnosis of pro- dementia. R91 had physician orders dated diazepam (Valium) at bedtime Trazodone (antidepressant uso sleeping aide) at bedtime for ir note text dated 11/14/14 ident medications, but did not includ for sleep or interventions to he	nent review, the nprehensive sleep ventions to control 91) admitted to the mnia and receiving assessed for imum Data Set admitted to the y 11/3/14 and had sician orders as anxiety, e CAA (care area 1/14/14 indicated w for mental rately impaired, and inimal depression ogressive ed 11/3/14 for e for anxiety, and ed out of class as a nsomnia The CAA ified these le an assessment		In response to the above stated Sauer Health Care has taken the action: " The facility policy titled, Care Comprehensive dated 3/3/2014 v reviewed and felt to be up to date current regulations. " The care plan for resident (R reviewed and modified on 12/16/ include monitoring sleep, side eff medication and also the addition possible non-pharmacological interventions that could be used to sleep. " Sleep monitoring was set up resident (R91) to assess for any concerns related to sleep and me use. Alternative interventions for have been put in place. " The sleep section of the Comprehensive Nursing Assessr (R91) was modified on 12/10/201 indicate her use of medicinal sleet diagnosis of insomnia and a note related to sleep as well as the ne sleep monitoring. " The Comprehensive Nursing Assessment was modified on 12/ to include a trigger for needed sleet monitoring and assessment base resident history, diagnosis and/or medication use.	following Plans vas with 91) was 2014 to ects of of to elicit for issues or edication sleep ment for 4 to ep aids, ed issue ed for (10/2014 eep ed on

Facility ID: 00705

TATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) DA). 0938-039 TE SURVEY MPLETED
		245102	B. WING		/25/201 <u>4</u>
	PROVIDER OR SUPPLIE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 272	without medicatic could cause or ex- identify sleep dist The facility's Com Assessment for a identify a sleep d symptoms/behav managing the ins Registered nurse 11/21/14 at 10:50 necessary to look insomnia and dep to regulations. F R91's sleep patte	on. The CAA list of factors that cacerbate the behaviors did not curbances. hprehensive Nursing admission effect 11/3/14 did not isturbance or behavior/mood iors or interventions for omnia or behavioral symptoms. (RN)-B was interviewed on 0 a.m. RN-B stated it was not cat the medications for anxiety, pression for 3 months according RN-B noted the facility monitored ern.	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 responsibilit of the Director of Nursing Services. 	f
SS=D	The assessment resident's status. A registered nurs each assessmen participation of he A registered nurs assessment is co Each individual w	ORDINATION/CERTIFIED must accurately reflect the e must conduct or coordinate t with the appropriate ealth professionals. e must sign and certify that the ompleted. tho completes a portion of the t sign and certify the accuracy of			1/4/13

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		I AND HUMAN SERVICES E & MEDICAID SERVICES		FORM	01/06/2015 APPROVED 0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		TE SURVEY MPLETED
		245102	B. WING	11	/25/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE	
SAUER I	HEALTH CARE			VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 278	Continued From pa	age 11	F 278		
	willfully and knowin false statement in a subject to a civil me \$1,000 for each as willfully and knowin to certify a materia resident assessme penalty of not more assessment. Clinical disagreeme material and false				
	by: Based on interview facility failed to acc pressure ulcer on t assessment, for 1 admitted with curre Findings include: R28 had been adm admission Minimur identified but not lin pressure ulcer pres area assessment of stage II pressure u However, the nursi noted scabbed are area is considered not knowing how d be.	NT is not met as evidenced v and document review, the urately assess an unstageable he initial comprehensive skin of 2 residents (R28) who were ent pressure ulcers. n Data Set (MDS) dated 7/9/14 nited to diagnoses of a stage II sent on admission. The care lated 7/16/14 read, "has a lcer on her left lateral ankle" ng assessment dated 7/3/14 a and the coding for scabbed and unstageable ulcer due to eep or extensive the ulcer may ursing Assessment dated		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	1

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		HAND HUMAN SERVICES	I	FC	ED: 01/06/2015 0RM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	· · · · · · · · · · · · · · · · · · ·	DATE SURVEY COMPLETED
		245102	B. WING		11/25/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER H	EALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 278	Continued From p	age 12	F 278		
	7/3/14 read, " Site Scabbed area Ler identified, Stage I. Other (specify) red Comments: Site 4 dressing." The Wound Assess forms dated and ir indicated the initia the time ulcer was pressure ulcer to t Skin/Wound Nurse read, "reported t resident's left oute [centimeter] of red center 0.75 x 0.6 d comprehensive as sheet modified and record] updated. S Weekly MDS sum 7/11/14 read, "S boarded dressing	e 48) Left ankle (outer): light: .75, Width: .6, Depth: Not Site 48) Left ankle (outer): l/blanching Length: 2, Width: 9. 8 has been covered with foam esments: Ulcer Information nplemented on 7/16/14 I stage of the pressure ulcer at first identified, was a stage II he left lateral malleolus. e progress noted dated 7/4/14 o observe a scabbed area on r ankle. The area: 2 x 3 cm den area with a scab in the cm. A foam pad was applied, sessment updated, skin flow d TAR [treatment administration che reports no pain at this time." mary progress note dated taff monitors placement of foam to right ankle, which prevents a scabbed area encircle with		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 AMT wound nurse. This tablet has educational materials built in as well as built in secure video communication package allowing for ongoing staff train as well as access to the AMT wound nurse as needed to assist with evaluati for staging and treatment guidance. " The current policies for skin care a pressure ulcers are being reviewed wit 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 resident to notify Administrator of any concerns that staff do not address. " Education was provided to staff at in-service training on 12/11/2014. All s	the s a hing ons nd h
	read, "Staff repo lateral malleolus. I an ulcer present w	e progress noted dated 7/16/14 rted a wound to R28's left Jpon assessment, there was rith a thick yellow slough in the cleansed, and all sloughs was		will be trained on all plan of care information by 1/4/2015. "Citation and plan for corrective acti and ongoing prevention to be reviewed QA meeting on 1/13/2015.	
	removed to reveal measuring 0.5 cm It had minimal ser- there was a scab report that R28 pro-	a pink/white wound bed x 0.8 cm with a 0.2 cm depth. ous drainage. Upon admission, noted in this location. Staff efers to sleep on her left side as pressure to this area. Have		Compliance for adherence to this plan be the responsibility of the RN unit managers and the licensed staff as we as the MDS Coordinator with overall compliance being the responsibility of t Director of Nursing Services.	II

Facility ID: 00705

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/06/2015 APPROVED 0938-0391
-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245102	B. WING		11/;	25/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278	provided R28 with be worn at all times pressure to the area [American medical on treatment." Medication Adminis 8/10/14 read, "Mor malleolus QOD [ev on ulcer tracking fo Medication Adminis 8/10/14 read, "No where scab was is documentation. Wi painting until area [discontinue] tx [tree [continue] to monite On 11/20/14 at 1:4 stated a pressure of would be unstagea what the area bene verified the admiss coded inaccurately and stated the MD an unstageable press present on admiss Wound Assessment s unstageable press present on admiss	vascular boots and they should s when she is in bed to prevent a. Have consulted AMT technologies] nurse for advice stration progress noted dated htor ulcer to left lateral rery other day], and document orm. Area scabbed." stration progress noted dated ulcer remains. No scab. Area slightly discolored. Resolving Il continue with Betadine	F 278			

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RS FOR MEDICARE & MEDICAID SERVICES		ОМ	NTED: 01/06/2015 FORM APPROVED <u>B NO. 0938-0391</u> X3) DATE SURVEY
	A. BUILDING		COMPLETED
245102 PROVIDER OR SUPPLIER	B. WING	IREET ADDRESS, CITY, STATE, ZIP CODE	11/25/201 <u>4</u>
IEALTH CARE			
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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
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." 483.20(d), 483.20(k)(1) DEVELOP	F 278		1/4/15
	245102 PROVIDER OR SUPPLIER TEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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." 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	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI Normal Construction NUMBER: IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING 245102 B. WING S PROVIDER OR SUPPLIER 245102 B. WING S FEALTH CARE ID ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. F 278 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 wound committee will monitor and audit resident treatment plan monthly." F 279 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F 279 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.	IMENT OF HEALTH AND HUMAN SERVICES OM SP FOR MEDICARE & MEDICAID SERVICES OM OP DEFICIENCIES (X1) PROVIDER/SUPPLERICUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION IN PROVIDER OR SUPPLIER 245102 STREET ADDRESS, CITY, STATE, ZIP CODE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE PROVIDER OR SUPPLIER 245102 STREET ADDRESS, CITY, STATE, ZIP CODE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE VEALTH CARE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE VEALTH CARE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE VIDENTIFYING INFORMATION ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE ISSUED SERVICE ORIVE Continued From page 14 ulcer to the left lateral malleolus present on admission. The DON verified the admission MDS should have aveed. 8. an unstageable pressure based on the documentation in the medical record. F 278 F 279 Pressure ulcer risk assessment policy dated 23/309 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 weekle. 8. The interdisciplinary meeting (IDT) twice a weekle. 8. The interdisciplinary wound committee will monthly." 438.20(d), 433.20(k

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		AND HUMAN SERVICES		FOF	ED: 01/06/2015 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION (X3) [OATE SURVEY OMPLETED
		245102	B. WING		1/25/2014
				STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE	
SAUER H	IEALTH CARE		· · ·	WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 279	Continued From pa	age 15	F 279		
	by: Based on observa review, the facility f related to monitorin related to the resid includes medicatio for 1 of 5 residents unnecessary media Findings include: R39 was observed sitting in a wheelch wife stated R39 ha months because st at home. R39 was readmitte and had diagnoses dated 10/24/14 as coronary atheroscl (Parkinson's) , hyp hypertrophy prosta anticoagulants, hyp dementia. R39's physician oro low sodium/low che including aspirin ar hypertonicity of bla prostate, torsemide congestive heart fa R39's care plan pri	on 11/18/14 at 10:55 a.m. hair with feet on floor. R39's d been in the facility for two he was unable to care for him d to the facility on 10/24/14 a listed on the physician orders chronic kidney disease, gout, erosis, paralysis agitans ertonicity of bladder, te, long-term use of bertension, depression, ders included: fluid restriction, blesterol diet. Medications ad Coumadin, Detrol for dder, Flomax, for hypertrophy e and Zestril diuretics for hilure.		In response to the above stated citation Sauer Health Care has taken the followin action: " On 11/26/14 the following memo was sent to the nursing staff from the DON we 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 an in place for that resident to be sure we and 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 complete 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 a	ng sia n re re s d
	interventions to dire	not include problems or ect staff related to the diet and out, the use of medications for		" Education was provided to staff at a in-service training on 12/11/2014. All sta will be trained on all plan of care	

Facility ID: 00705

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION (X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED
NAME OF	245102		B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE	/25/201 <u>4</u>
SAUER	HEALTH CARE			635 WEST SERVICE DRIVE /INONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 279 F 280 SS=D	bladder and pros to identify incontii include the use o for bleeding in wh alerted to in case that need immed The facility's polid Plans-Comprehe comprehensive o measurable object resident ' s medio psychological neet resident." The director of no 11/25/14 at 9:57 at did not include por medications for a pressure, depress restrictions. 483.20(d)(3), 483 PARTICIPATE PI The resident has incompetent or o incapacitated und participate in plan changes in care at A comprehensive a interdisciplinary to physician, a regis for the resident, at disciplines as def	tate issues or diuretic use except nence. The care plan did not f Coumadin and aspirin and risk nich the nursing aides need to be of bleeding or other symptoms iate interventions. cy dated 3/3/14 entitled Care nsive noted an "individualized are plan that includes ctives and timetables to meet the cal, nursing, mental and eds is developed for each ursing (DON) was interviewed on a.m. and verified the care plan ossible side effects related to inticoagulants, high blood sion, special diet and fluid 8.10(k)(2) RIGHT TO ANNING CARE-REVISE CP the right, unless adjudged therwise found to be der the laws of the State, to oning care and treatment or	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 wil 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.	

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		AND HUMAN SERVICES		FOR	D: 01/06/2015 M APPROVED O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		ATE SURVEY OMPLETED
		245102	B. WING		1/25/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE	
SAUER I	EALTH CARE			VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 280	Continued From pa	age 17	F 280		
	legal representative	sident's family or the resident's e; and periodically reviewed am of qualified persons after			
	by: Based on observa review the facility fa include personal hy residents (R65) with Findings include: R65 was observed 11/25/14 at 9:40 a. chin and neck. The annual Minimu indicated R65 requi one staff with perso dated 10/21/14 ind perform some of hy following staff assis plan did not indicate with shaving or obt The nursing assista required assist of of The flow sheet did shaving of facial has The facility policy of Plans-comprehenss Planning/Interdisci	on 11/18/14 at 9:00 a.m. and m. with long facial hair on her im Data Set dated 10/21/14 ired extensive assistance of onal hygiene. The care plan icated R65 was able to er own personal hygiene stance with set up. The care e if R65 needed assistance aining a razor. ant flow sheet indicated R65 ine with activities of daily living. not indicate the need for		In response to the above stated citation Sauer Health Care has taken the followin action: "On 11/26/14 the following memo was sent to the nursing staff from the DON vie 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 Ur RN, you need to add this for (R65) immediately) if she does it independently or refuses to allow us to do it then that to 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 ow 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	nit nit

Facility ID: 00705

If continuation sheet Page 18 of 39

					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			E SURVEY PLETED
		245102	B. WING			25/201 <u>4</u>
NAME OF	PROVIDER OR SUPPLIE			TREET ADDRESS, CITY, STATE, ZIP CODI		
SAUER I	IEALTH CARE		-	635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	11/25/13 at 10:03	ursing (DON) was interviewed on 3 a.m. DON stated care plan and t flow sheet should address the	F 280	encourage/remind resident to p task. However, given the fact t is alert and oriented and staff r or encourage her to complete resident at times may refuse to this task. "The CNA flow sheets were for (R65) on 12/18/2014 to dire staff to remind resident to shaw the service to her and to repor "The facility policy titled, Ca Comprehensive dated 3/3/201 reviewed and felt to be up to d current regulations. "An audit to evaluate the pr unwanted facial hair was comp 12/9/2014. "A random audit of facial ha completed at the discretion of ensure shaving of all unwanted is done for all residents. "Administrator attended res council on 12/2/2014 reviewed with residents and encouraged to notify Administrator of any c that staff do not address. "Education was provided to in-service training on 12/11/20 will be trained on all plan of ca information by 1/4/2015. "Citation and plan for correct and ongoing prevention to be r QA meeting on 1/13/2015. Compliance for adherence to t be the responsibility of the nurs department staff members with compliance being the responsi	hat resident may remind this task, o complete a updated ect CNA ve or offer t refusals. The Plans 4 was ate with esence of oleted on air will be the DON to d facial hair sident citations I residents oncerns staff at an 14. All staff re ctive action reviewed at his plan will sing n overall	

Event ID: 27LG11

Facility ID: 00705

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		AND HUMAN SERVICES		FORM	01/06/2015 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION (X3) DATI	0938-0391 E SURVEY PLETED
	PROVIDER OR SUPPLIER	245102	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE WINONA, MN 55987	25/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 SS=D	PERSONS/PER C/ The services provided b accordance with ea care. This REQUIREMED by: Based on observa review the facility fa personal hygiene for (R31) reviewed for Findings include: R31 had been adm quarterly Minimum 10/30/14, identified dementia and requ person for persona During observation R31 had been in ro fingernails on her ri debris observed un fingernails. On 1/20 been in room sitting fingernails. R31's care plan da self-care deficit rela interventions of but dependent on one	ded or arranged by the facility by qualified persons in ach resident's written plan of NT is not met as evidenced tion, interview and document ailed to follow the care plan for or nail care for 1 of 3 residents activities of daily living. itted on 5/15/14. R31's Data Set (MDS) dated but not limited to diagnoses of ired extensive assist of one	F 28	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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CENTER	RS FOR MEDICAR	HAND HUMAN SERVICES		OMB NO	: 01/06/20 1 APPROVE . 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING _		TE SURVEY MPLETED
		245102	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	/25/201 <u>4</u>
NAME OF F	ROVIDER OR SUPPLIER			635 WEST SERVICE DRIVE	
SAUER H	IEALTH CARE			/INONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 282	Continued From p	age 20	F 282		
F 310 SS=D	nursing assistant (fingernails on R31 clean residents fin during bathing and would take care of today. During an observa- registered nurse (fingernails on R31 needed to be clea clean R31's finger needed. RN-B stat Wednesday in the During an interview director of nursing resident fingernails day and stated stat fingernails as need cares. During an interview DON stated she c fingernails would be extensive assist of verified the care p R31. A policy was comprehensive car was not provided.	tion on 11/21/14 at 10:27 a.m., NA)-A verified the dirty 's right hand. NA-A stated staff gernails on their bath days as needed. NA-A stated she cleaning R31's fingernails tion on 11/21/14 at 10:28 a.m., RN)-B verified the dirty 's right hand and stated they ned. RN-B stated staff was to nails on her bath day and as ted R31 had her bath day on morning. w on 11/21/14 at 10:44 a.m. the stated she expected all s to be cleaned on their bath ff should clean resident ded as a part of their daily w on 11/21/14 at 11:30 a.m., the onsidered ensuring clean be included in providing f one for personal hygiene and lan had not been followed for requested for following the re plan at this time and one S DO NOT DECLINE UNLESS	F 310	 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. 	
00-0	Based on the com resident, the facilit abilities in activitie	prehensive assessment of a y must ensure that a resident's s of daily living do not diminish ces of the individual's clinical			

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		AND HUMAN SERVICES		FORM	01/06/2015 APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	` ´	TE SURVEY MPLETED
		245102	B. WING		/25/2014
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE	
			v	VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 pa	age 21	F 310		
	unavoidable. This to bathe, dress, an ambulate; toilet; ea	rate that diminution was includes the resident's ability d groom; transfer and at; and use speech, language, communication systems.			
	by: Based on observa review the facility faremoved per reside (R65) observed with Findings include: R65 was observed long facial hair on the she would generall the razor was dull. about an inch in let R65 was observed and neck. The res have it again" in re long chin hair. R65 razor and she wou her. R65 stated it was long. The annual Minimu	on 11/18/14 at 9:00 a.m. with her chin and neck. R65 stated y have them shaved, but that The facial hair was gray and ngth. On 11/25/14 at 9:40 a.m. to have facial hair on the chin ident commented "Oh do I gards to the question about the 5 stated staff use their own Id forget to tell them to shave bothered her if the facial hair		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 Uni 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.	t
	one staff with perso dated 10/21/14 ind perform some of h following staff assist nursing assistant fl required assist of c Neither the care pl	ired extensive assistance of onal hygiene. The care plan icated R65 was able to er own personal hygiene stance with set up. The ow sheet indicated R65 one with activities of daily living. an or flow sheet did not or shaving of facial hair.		 Following the above noted email the unit manager revised the care plan for resident (R65) as follows on 11/26/2014. 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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		RE & MEDICAID SERVICES			NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING) DATE SURVEY COMPLETED
		245102	B. WING		11/25/201 <u>4</u>
NAME OF	PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE		-	635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
F 310	Continued From	page 22	F 310		
	11/25/13 at 10:03	ursing (DON) was interviewed on 8 a.m. and stated the nursing o have a resident shaved as part ares.		task. However, given the fact that resid is alert and oriented and staff may rem or encourage her to complete this task resident at times may refuse to complet this task. " The CNA flow sheets were update for (R65) on 12/18/2014 to direct CNA staff to remind resident to shave or offi- the service to her and to report refusal " Social Services Director spoke wit Resident (R65) daughter on 12/16/201 address the resident s report of her ra- being dull. Daughter reported that she would purchase a new razor and drop 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 unwanted facial hair was completed or 12/9/2014. " A random audit of facial hair will be completed at the discretion of the DON ensure shaving of all unwanted facial h is done for all residents. " Administrator attended resident council on 12/2/2014 reviewed citation with residents and encouraged resider to notify Administrator of any concerns that staff do not address. " Education was provided to staff at in-service training on 12/11/2014. All s will be trained on all plan of care information by 1/4/2015. " Citation and plan for corrective act	anind sete d er s. h 4 to azor it s of n e N to hair s an staff

Facility ID: 00705

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		FORM	: 01/06/2015 1 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		TE SURVEY MPLETED
		245102	B. WING		/25/2014
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 535 WEST SERVICE DRIVE	
SAUER	HEALTH CARE		v	/INONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 pa	age 23	F 310	QA meeting on 1/13/2015.	
				Compliance for adherence to this plan wil 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 CAT RESTORE BLADD	HETER, PREVENT UTI, ER	F 315		1/4/15
	assessment, the fa resident who enters indwelling catheter resident's clinical c catheterization was who is incontinent treatment and serv	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder e.			
	by: Based on interview facility failed to con tract infection (UTI) individualized plan (R51,R14, R78, R4 recurrent urinary tra Findings include: R51 developed urin 5/13/14, 6/27/14, 8 9/13/14 R51 was d to gram negative o	NT is not met as evidenced v and document review, the pprehensively assess urinary of care for 5 of 5 residents 8, R20) with a history of act infections.		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	

Facility ID: 00705

		AND HUMAN SERVICES		FORM	01/06/201 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		E SURVEY IPLETED
		245102	B. WING	11/	25/2014
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER H	IEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 pa	age 24	F 315		
	intravenous antibic history and physica had been admitted	otics. Review of the hospital al (H & P) dated 9/13/14 R51 to the hospital related to	1 010	or modified as resident is no longer in the facility, having been discharged or expired.	
	complicated UTI in (history and physic been seen in the e	E coli bacteremia from a January 2014. The H & P al) indicated R51 had also mergency room on 8/26/14		Care plan for (R14) has been reviewed and modified as of 12/11/2014 and 12/19/2014 to include interventions for infection prevention.	
		h a UTI. y and physical dated 9/13/14 2 was admitted to the hospital		" Care plan for (R20) has been reviewed and modified as of 12/19/2014 to include interventions for infection prevention.	
	related to septic sh stated R51 was dis damage from the s	nock secondary to infection and splaying signs of end organ shock. The H & P indicated		" Care plan for (R51) has been reviewed and modified as of 12/19/2014 to include interventions for infection	
	indicated acute kid	nt problem. The H & P also Iney injury related to the sepsis, need for aggressive hydration.		prevention. Care plan for (R78) has been reviewed and modified as of 12/19/2014 to include interventions for infection	
	for R51 dated 11/1 reviewed. The ass	rehensive nursing assessment 2/14 was provided and sessment noted a bowel and		prevention. " The facility policy titled, Care Plans Comprehensive dated 3/3/2014 was	
	of bladder and stor medical issues inc	ndicated R51 was incontinent ol, had terminal end stage luding prostate cancer, had a ory of frequent UTIs, The		reviewed and felt to be up to date with current regulations. " The facility policy titled, Urinary Tract Infection (UTI) Prevention and	
	assessment lacked for developing urin	d identification of risk factors ary tract infections, such as s related to catheter use,		Management dated 2/3/2009 has been modified as of 12/19/2014. New policy title, Urinary Tract Infection (UTI)	
	medical conditions	s or co-morbidity related to , cognitive function, cal function or environment.		Identification, Treatment, Prevention and Management will be reviewed for approval at the QA meeting on 1/13/2015. Implementation or further modification to	
	focus of " was hos bacteremia, history	printed 11/25/14 included a spitalized with urosepsis with of MRSA (methylene resistant		be made following that meeting. " A random audit of care plan topics, goals and interventions will be completed	
	practitioner on 3/28 colonized, and had	reus) in urine that the nurse 5/14 noted R51 was likely I an in dwelling catheter related The interventions directed		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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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	PRINTED: 01/06/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER	245102	1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	11/25/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 315	staff to change the signs of a UTI. The staff with approache recurrent UTIs. R14 developed urin 7/17/14, 8/14/14, 9/ interventions to pre- developing. The facility's compr dated 9/23/14 noted bladder, predisposit and a bowel ostomy identification of risk tract infections, suc co-morbidity related cognitive function, r or environment. R14's care plan prir was frequently inco interventions related minimize the risk of R78 developed urin 6/16/14. On 6/12/1 with C-Diff (Clostrid dif-uh-SEEL), often infection according The facility's compr dated 9/17/14 indica incontinent, had a c occasionally leak. identification of risk tract infections, suc related to catheter of	catheter and observed for einterventions did not provide es to help minimize the risk of ary tract infections on 6/9/14, 12/14 and lacked vent more UTIs from ehensive nursing assessment d infrequent incontinence of ng factors for incontinence χ . The assessment lacked factors for developing urinary h as contributing factors or I to medical conditions, nedications, physical function hted 11/25/14 indicated R14 ntinent of urine, but lacked d to approaches to help recurrent UTIs. ary tract infections on 5/2/14, 4 R78 was also diagnosed ium difficile (klos-TRID-e-um called C. difficile or C. diff) to the infection control log. ehensive nursing assessment ated R78 was occasionally	F 315	Management of Urinary Tract In Long Term Care from TOP (Tow Optimized Practice Program). T document includes the Clinical F Pieces of this document will be providing training to staff. " Administrator attended resid council on 12/2/2014 reviewed of with residents and encouraged of to notify Administrator of any cou- that staff do not address. " Education was provided to s in-service training on 12/11/2014 will be trained on all plan of care information by 1/4/2015. " Citation and plan for correct and ongoing prevention to be re QA meeting on 1/13/2015. Compliance for adherence to this be the responsibility of the RN u managers and the licensed staff as the MDS Coordinator and Inf Control Nurse with overall comp being the responsibility of the Di Nursing Services.	vard his Pathway. used in dent citations residents ncerns staff at an 4. All staff wive action viewed at is plan will init f as well ection viance

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		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER	245102	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	11/25/2014
				1635 WEST SERVICE DRIVE WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE COMPLÉTIC
F 315	Continued From p	290.26	E 04	DEFICIENCY)	
1 313		medications, or assessments d lead to septicemia and	F 31	15	
	indicated a diagno chronic indwelling directed staff to ch for signs of a UTI.	an printed 11/25/14 that sis of neurogenic bladder and catheter. The interventions ange the catheter and observe The interventions did not approaches to help minimize at UTIs.			
		ary tract infections on 6/15/14, ed interventions to reduce UTIs.			
	9/5/14 indicated R of bowel and blade predisposing incor assessment lacker for developing urin contributing factors	e nursing assessment dated 8 was occasionally incontinent ler and had no untreatable atinence risk factors. The d identification of risk factors ary tract infections, such as s or co-morbidity related to , cognitive function,			
	longstanding histo urgency and direct urinary tract infecti	rinted 11/25/14 indicated a ry of urinary frequency and ed staff to monitor for signs of ons. The interventions did not approaches to help minimize at UTIs.			
		nary tract infections on 4/29/24, interventions to prevent			
	9/12/14 indicated I	e nursing assessment dated R20 was occasionally dependent with toileting and			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES		FC	TED: 01/06/2015 ORM APPROVED NO. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245102	B. WING		11/25/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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	The assessment la factors for develop such as contributin related to medical medications, physi The plan of care pr longstanding diagn interventions to ide interventions did no approaches to help UTIs. The director of nur 11/25/14 at 2:30 p. comprehensive nu plans were comple stated no other ass	ing factors for incontinence. Incked identification of risk ing urinary tract infections, g factors or co-morbidity conditions, cognitive function, cal function or environment. Finted 11/25/14 had a focus of osis of stress incontinence and intify signs of UTI. The	F 315		
F 371 SS=F	minimize the risk o completed. The facility policy e (UTI) Prevention a did not direct nursi for the risk of deve and did not direct t individualized care approaches to him urinary tract infection 483.35(i) FOOD PI STORE/PREPARE The facility must - (1) Procure food from	f recurrent infections had been entitled Urinary Tract Infection nd Management dated 2/3/09 ng staff to assess a resident loping urinary tract infections he development of an plan to assist staff with minimize the risk of recurrent ons.	F 371		1/4/15

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		AND HUMAN SERVICES			RINTED: 01/06/2015 FORM APPROVED JB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		245102	B. WING		11/25/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 371	Continued From pa (2) Store, prepare, under sanitary con	distribute and serve food	F 371		
	by: Based on observa review, the facility is shelving in 2 of 2 w in a clean and sani potential to affect a that had been providistributed from the Finding Include: During the initial ki p.m., with cook (C) was observed to has spots, hanging cluu in varying colors of second walk-in cool out of 23 shelves of clumps, and fuzzy colors of gray, gree On 11/17/14 at 6:1 identified shelves i with spots, hanging debris in varying cool Cook-A verified the the floors of the wa cleaned on Wedne	tchen tour on 11/17/14, at 6:10 A the walk-in dairy cooler ave 6 out of 18 shelves with mps, and fuzzy areas of debris gray, green and black. The oler was observed to have 15 observed with spots, hanging areas of debris in varying en and black. 7 p.m. C-A verified the n the walk-in coolers had areas g clumps, and fuzzy areas of olors of gray, green and black. e cleaning schedule indicated alk-in coolers were to be esdays and verified the cleaning iclude cleaning the shelving in		In response to the above stated cita Sauer Health Care has taken the fo action: " The shelving in the coolers was cleaned with Sanotracin RTU produ food that was not in a sealed manufacturer s container was disp of on 11/17/14 by 11:15 pm when th issue was noted by the survey team " RD was notified of the above cit on 11/18/2014 via email. " Education to all dietary staff on clean the coolers and changes to th cleaning schedule was started on 11/18/2014 and completed on 12/11 " The schedule for cleaning and monitoring the cooler spaces was u as of 11/24/2014. " Policy titled, General Sanitizatio Kitchen was reviewed by Dietary ma and RD, no changes made. " All dietary staff will be scheduler receive education via webinar from Reinharts. To be completed by 1/4/ " Administrator attended resident council on 12/2/2014 reviewed citati with residents and encouraged resident contify Administrator of any concer that staff do not address. " Education was provided to staff	Ilowing ict and osed is n. tation how to re 1/2014. pdated on of anager d to 2015. ions dents rns

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	PRINTED: 01/06/20 FORM APPROVE OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER	245102	1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	11/25/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIC
F 371	p.m., with another dietary manager ((identified shelves the fifteen identifie cooler had areas w fuzzy areas of deb green and black. T concern on the ide coolers were mold shelving in the wai the daily Cleaning During an interview administrator state cleaned. The adm the policy and veri not specifically list walk-in coolers. During a kitchen o the CDM on 11/18 walk-in cooler was cleaned and had e The second walk-i been cleaned and shelves initially ob stated some of the walk-in cooler was of its condition. Th abatement contrad last night by maint on how to clean th the mold concern. in both walk-in cool shelves, the walls Sanotracin RTU, a recommended by	age 29 bservation on 11/17/14, at 8:50 surveyor and the certified CDM), the CDM verified the six in the walk-in dairy cooler and of shelves in the second walk-in with spots, hanging clumps, and tris in varying colors of gray, The CDM stated the areas of entified shelving in the walk-in l. The CDM verified the lk-in coolers was not listed on Schedule in the kitchen. W on 11/18/14, at 7:45 a.m., the ed the refrigerators have been inistrator stated she reviewed fied the policy/procedure does cleaning of the shelves in the bservation and interview with /14, at 8:47 a.m., the dairy observed to have been eighteen shelves in the cooler. n cooler was observed to have had only 16 out of the 23 served in the cooler. The CDM e shelving from the second going to be replaced because the CDM stated Asbesbegon (an ctor) company was contacted enance for a recommendation e walk-in coolers because of The CDM stated the shelving olers was power washed, all the and flooring was cleaned with a mold killing chemical Asbesbegon. The CDM stated dits of the kitchen areas but	F 371	in-service training on 12/11/201 will be trained on all plan of car information by 1/4/2015. "Citation and plan for correct and ongoing prevention to be re QA meeting on 1/13/2015. Compliance for adherence to th be the responsibility of the dieta department staff along with the maintenance department with of compliance being the responsi Dietary Department Manager.	re ctive action eviewed at his plan will ary poverall

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		AND HUMAN SERVICES			RINTED: 01/ FORM APF MB NO. 093	ROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		245102	B. WING		11/25/2	014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE		
SAUER I	HEALTH CARE			VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COI	(X5) MPLETION DATE
F 371	the shelves in the w The CDM stated sl morning and discu- aware of cleanlines stated, "I don't kno happened. There is not have happened staff will be re-edua and sanitary kitche schedule will be re- the walk-in coolers During an interview director of nursing documentation of t illness in the kitche between staff illnes mold found in the k The General Sanita 12-7-11 read, "The maintain the sanita compliance with a cleaning schedule. Procedure: 1. Cleaning and sa will be recorded. 2. Tasks will be ass of specific position: 3. Tasks will be add cleaning. 4. A cleaning schedule.	enough because the mold on walk-in coolers was missed. he had a staff meeting this ssed the need for staff to be ss in the kitchen. The CDM w what to say. I am upset this s nothing I can say. It should d." The CDM stated all kitchen cated on maintaining a clean n and the daily cleaning vised to include the shelving in o on 11/18/14 at 9:34 a.m., the (DON) stated she reviewed the racking and trending of staff in and there was no correlation ss that can be related to the citchen walk-in coolers. ation of Kitchen policy dated Dietary Services staff shall tion of the kitchen through written, comprehensive	F 371			
F 441 SS=E	483.65 INFECTION	N CONTROL, PREVENT	F 441		1/4	/15

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/06/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245102	B. WING		11/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 31	F 441			
	The facility must es Infection Control P safe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.				
	The facility must es Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied t	stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective				
	determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each d	tion Control Program esident needs isolation to of infection, the facility must the prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted				
		ndle, store, process and as to prevent the spread of				
	This REQUIREME by:	NT is not met as evidenced				

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		RE & MEDICAID SERVICES			IB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	.E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		245102	B. WING		11/25/201 <u>4</u>
NAME OF I	PROVIDER OR SUPPLI	ER	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441	Continued From	page 32	F 441		
	facility failed to id infections (UTI), monitor and anal recurrent UTIs a staff education for R20, R8 and R74 infections and for ((R19, R67, R25 R64, R31, R56, R identified by the between April an Findings include R51 developed 5 April 24, 2014 ar an indwelling cat completed by the R51 would displa possible UTI (be blood pressure of symptoms were was identified different antibioti same micro-orga R14 developed 4 June 2014 and 5	5 urinary tract infections between ad September 12, 2014. R51 had theter. Documentation e infection control nurse indicated ay one symptoms indicating a haviors, confusion, agitation, changes). On two occasions 2 identified. The micro-organism r three of the infections and each the same micro-organism. Two ics were identified used for the anism. 4 urinary tract infections between September 2014.		In response to the above stated cital Sauer Health Care has taken the fol action: " The Bowel & Bladder section of Comprehensive Nursing Assessmer modified on 12/10/2014 to include a question about a history of frequent recurring UTI s. If this is indicated trigger the nurse to create a care pla addressing UTI Risk. These assessments are completed at adm quarterly and at any time of a noted change of condition. " Care plan for (R8) was not revie or modified as resident is no longer facility, having been discharged or expired. " Care plan for (R14) has been reviewed and modified as of 12/11/2 and 12/19/2014 to include interventio for infection prevention. " Care plan for (R20) has been reviewed and modified as of 12/19/2 to include interventions for infection prevention. " Care plan for (R51) has been reviewed and modified as of 12/19/2 to include interventions for infection prevention. " Care plan for (R78) has been	lowing the nt was or it will an ission, wed in the 014 ons 2014
	nurse indicated F of the infections. documentation in other infection do symptoms had b	completed by the infection control R14 had displayed only falls for 2 The June infection Indicated 3 symptoms and the ocumentation indicated 2 ieeen identified. Two different		reviewed and modified as of 12/19/2 to include interventions for infection prevention. " The facility policy titled, Care Pla Comprehensive dated 3/3/2014 was reviewed and felt to be up to date with	ans
	symptoms had b micro-organisms infections. In Ju				th

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		RE & MEDICAID SERVICES			D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		ATE SURVEY OMPLETED
	$2 \cap 1$	245102	B. WING		1/25/201 <u>4</u>
NAME OF I	PROVIDER OR SUPPLIE			TREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER H	HEALTH CARE			635 WEST SERVICE DRIVE VINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 33	F 441		
	contaminated an	d the antibiotic was continued.		Management dated 2/3/2009 has been modified as of 12/19/2014. New policy	
	case only one sy case two differer	2 urinary tract infections. In each mptom was identified. In each at organisms were identified for		title, Urinary Tract Infection (UTI) Identification, Treatment, Prevention and Management will be reviewed for approve	al
	each infection.	urinary tract infections. Only one		at the QA meeting on 1/13/2015. Implementation or further modification to be made following that meeting.	
	or two symptoms did not have an i	were identified. One infection dentified micro-organism and the		" The infection control nurse will track individual resident infections and any	
	other infection id responsible for th	entified two micro-organisms ne infection.		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	
	had a indwelling	e urinary tract infections. R78 catheter. Two symptoms were		and the medical director to identify any other needed action or intervention.	
		h infection, but only one infection cro-organisms responsible (2).		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	1
		ntrol nurse documentation was ocumentation did not note that		Control Nurse. " A random audit of care plan topics,	
	not correspond to	entified symptoms present did o the policy (3 symptoms for I 2 symptoms if catheter). The		goals and interventions will be completed at the discretion of the DON to ensure individualization is in place.	
	analysis provided not identify trend	d for the quality committee did s of recurrent UTIs of or		" The 13 page document titled, Guideline for the Diagnosis and	
	recurrent micro-o	organisms.		Management of Urinary Tract Infections i Long Term Care from TOP (Toward Optimized Practice Program). This	n
	(UTI) Prevention read, :	and Management dated 2/3/09		document includes the Clinical Pathway. Pieces of this document will be used in	
	to treat UTI witho	asymptomatic UTI. Indications but a catheter should have 3 of fever, b) increased burning, pain		providing training to staff. Administrator attended resident council on 12/2/2014 reviewed citations	
	on urination, freq pain d)change in	uency, or urgency, c)new flank character of urine, e) worsening		with residents and encouraged residents to notify Administrator of any concerns	
		tional status. asymptomatic UTI. Indications h a catheter must have 2 of the		that staff do not address. "Education was provided to staff at an in-service training on 12/11/2014. All sta	

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CENTER		H AND HUMAN SERVICES		E CONSTRUCTION	FORM OMB NO.	01/06/201 APPROVEI 0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · /	PLETED
		245102	B. WING		11/2	25/2014
NAME OF F	PROVIDER OR SUPPLIE	R	ST	TREET ADDRESS, CITY, STATE, ZIP COD		
SAUER H	EALTH CARE			635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From p	bage 34	F 441			
	following: a) fever change in characc 22 other residents episode of UTI du through October 2 nurse documenta lacked the 2 or 3 accordance with the control nurse doc of the micro-organ provided by the d a repetition of mice residents with infer *April 2014 3 UT resident was not if symptoms listed, infection control in this resident. *May 2014. 7 not identified above indicated only one The micro-organis one symptom of ea an elevated white noted. R38 had co as an indicator of a U reported. R44 ha as an indicator of were identified. Review of the doc Proteus mirabilis,	r or chills b) new flank pain, c) ter of urine." a also had developed a single uring the time period of April 2014. The infection control tion was reviewed. The reports symptoms identified in the policy and the infection umentation lacked identification nism. The analysis of data irector of nursing did not indicate cro-organisms between ections in a given month. Is identified by the facility-one identified above. R19 had 3 but no culture results. The burse had not documented on 7 UTIs identified by the facility-5 ve. R67 had documentation that a symptoms (behavior change). sm was identified. R25 had elevated temperature and also count. The culture results were only one symptom documented a UTI, no micro-organism was one symptoms documented as JTI and no micro-organism was d two symptoms documented a UTI and 2 micro-organisms	Г 441	 will be trained on all plan of cainformation by 1/4/2015. " Citation and plan for correated ongoing prevention to be QA meeting on 1/13/2015. Compliance for adherence to be the responsibility of the RN managers and the licensed states as the Infection Control Nurse compliance being the response Director of Nursing Services. 	ective action reviewed at this plan will l unit aff as well with overall	
	infections. *June 2014 6	-organisms identified in 4 of the UTIs were identified by the as residents with multiple				

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CENTER TATEMENT	RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		RINTED: 01/06/201 FORM APPROVED MB NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245102	B. WING		11/25/201 <u>4</u>
NAME OF F	PROVIDER OR SUPPLIEI	R	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	HEALTH CARE		16	35 WEST SERVICE DRIVE	
SAUER P			W	NONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 444					
F 441	Continued From p	-	F 441		
		vas admitted to the hospital with			
		No information related to			
		ure results was identified on the			
		e summary or infection R75 had a catheter and had one			
		ented as an indicator of a UTI			
		sis. Two micro-organisms were			
	identified.	olo: Two micro organismo were			
		cumentation of the 6 UTIs			
		nonth three of the infections did			
	not have micro-or	ganisms listed by the infection			
	control nurse.				
		UTIs were identified by the			
		l as residents with multiple UTIs			
		er and had one symptom			
		dicator or a UTI. No			
		as identified by the infection			
		4 was admitted to the hospital			
		of UTI. The infection control ument symptoms or			
		R35 had two symptoms			
		ig a UTI and a micro-organism			
		eview of the documentation			
		d that all 4 infections lacked			
		ptoms as identified by the policy			
		bcumented micro-organism.			
	*August 2014 6 L	JTIs were identified for the			
		identified as residents with			
		R31 had two symptoms			
		nd a micro-organism listed.			
		ptoms and two micro-organisms			
		d one symptoms listed and no			
		dentified. Review of the surse documentation indicated			
		ections had identified			
	-	and three of the 4 had the same			
		, Klebsiella Pneumoniae, and			
		Only one of the 6 residents had	L		
	Proteus Mirabilis.	Only one of the bresidents had	1		

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		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/06/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245102	B. WING		11/:	25/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER	HEALTH CARE			635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	three residents ide multiple/recurrent I had no symptoms micro-organisms id infection control do the reports had inco potential UTI and o micro-organisms. *October 2014 3 U identified as having symptoms identifie micro-organism lis identified indicating identified. Review documentation ind the same micro-or lacked identifying s policy. A line listing of infe at 7:45 p.m. by the indicated this was quality assurance line listing did not i culture results, inte an interview on 11/ indicated infections monthly to identify on 11/21/14 at 2:0 the infection rate a QA committee proc During an interview director of nursing urinary tract infecti pattern. It had bee	4 UTIs identified by the facility- ntified as having UTIs and are listed above. R6 indicating a UTI listed but had dentified. Review of the ocumentation indicated one of licated symptoms identifying a only two had identified TIs were identified- 2 were not g recurrent UTIs. R87 had one ed indicating a UTI and a ted. R999 had one symptom g a UTI and micro-organism of the infection control icated two of the 3 UTIs had ganism identified-E-Coli and all symptoms according to the ctions was provide on 11/17/14 director of nursing. She the information provided to the (QA) committee meeting. The nclude the resident name, erventions or resolution. During '29/14 the director of nursing s were tracked on a map patterns. During an interview 0 p.m. the administrator stated nd information was part of the	F 441			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/06/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245102	B. WING		11/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		<u>. </u>
SAUER I	HEALTH CARE			635 WEST SERVICE DRIVE		
				VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 37	F 441			
		ne medical director had				
		residents would no longer but rather white blood cell				
	counts to determin	e a possible infection. The				
		indicated only 2 symptoms				
		determine a potential UTI and ure as directed in the standing				
	order. The sympto	ms would be determined by				
		t, notifying changes in istory. During the interview the				
		indicated if a resident had a				
		were to encourage fluids,				
	hand washing.	are, offer reminders, and good				
	When reviewing th	e infection reports with the				
		on 11/25/14 at 2:30 p.m. she				
		I that residents with catheters ent UTIs, but did not realize				
	that other residents					
		antibiotic effectiveness not				
	tracked:	entitled Infection Control dated				
		staff were to have appropriate				
		on managing infections in				
		icy also read, "Through g this facility will take				
		s per State and Federal				
		stigate, prevent, control and				
		infection." The policy identified ing Infections: as a)				
	investigation, b)dat	a collection as to type of				
		resident and facility or				
	, i	ed, c) calculate the data and r time to identify pattern,				
	clusters, trends and	d opportunities for				
		onitor for recurrent infections				
	in residents. During the interview	w on 11/25/14 at 10:44 a.m. the				
		stated the facility had a nurse				

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		H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM A	01/06/2015 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE	
NAME OF	PROVIDER OR SUPPLIER	245102	B. WING	STREET ADDRESS. C		11/2	5/201 <u>4</u>
	HEALTH CARE			1635 WEST SERVIC			
				WINONA, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD ERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	dedicated to infect assurance. DON control nurse's res implement infection reviews the report qualify committee. director was very in control program and During an interview director of nursing monitor micro-organ antibiotics. She are infections, not antit The administrator 2:00 p.m. She ind would be present and committee meeting meeting. The infe- and re-occurring in and reviewed by the administrator states the large number of nurse tracks the U infection control me educate staff on p	tion control and quality indicated it with the infection sponsibility to monitor and on control program. The DON is and takes this information to . DON indicated the medical involved with the infection and monitoring of infections. w on 11/25/14 at 10:52 a.m. the indicated the facility would anisms, but not track dded on resident specific logs, ibiotic use was tracked. was interviewed on 11/21/14 at licated the medical director at the quality assurance g and had input into the ection control list of infections infections would be discussed he medical director. The ed that she had not recognized of UTIs. The infection control UTIs and infections. The urse would be responsible to erineal care. The administrator concerns related to the	F 4	11			

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		AND HUMAN SERVICES & MEDICAID SERVICES	F	51	n1117	FORM	12/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245102	B. WING			11/1	19/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER H	HEALTH CARE				635 WEST SERVICE DRIVE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ſS	кc	000			8
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			18		
	Minnesota Departm Fire Marshal Division Sauer Health Care compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, was found not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In	R THE FIRE SAFETY			EPOC		
	State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145					
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electror	nically Signed						12/26/201

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245102	B. WING			11/	19/2014
	PROVIDER OR SUPPLIER			1	BTREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	VINONA, MN 55987 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s		ĸ	000			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
	3. The name and/o responsible for com prevent a reoccurre	r title of the person rection and monitoring to ence of the deficiency.					
	partial basement. T 5 different times. T constructed in 1966 Type III(211) constr constructed to the 3 determined to be of 1976, 1982, and 19 the North Wings th Type III (211) const building and the 4 a of construction allo	is a 1-story building with a The building was constructed at the original building was 5 and was determined to be of function. In 1972, addition was South Wing that was f Type III(211)construction. In 095 additions were added to at were determined to be of function. Because the original additions are of the same type wed for existing buildings, the ed as one building, Type					
	has a fire alarm sys corridors and space monitored for autor	r fire sprinklered. The facility stem with smoke detection in es open to the corridors that is matic fire department ngle station smoke alarms in			and the second s	-	

Facility ID: 00705

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES		FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		245102	B, WING	11/	19/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SAUER	EALTH CARE			1635 WEST SERVICE DRIVE WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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	Continued From pa	ge 2	K 00	00	
	The facility has a ca census of 62 at the	apacity of 71 beds and had a time of the survey.			
K 029	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 02	29	1/4/15
SS=D	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved autom option is used, the a other spaces by sm doors. Doors are s field-applied protect	construction (with ³ / ₄ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1			
7	Based on observat facility failed to mai partitions and doors following requirement	s not met as evidenced by: tion and staff interview, the ntain smoke-resisting s in accordance with the ents of 2000 NFPA 101, The deficient practice could idents.		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	
		veen 9:30 AM and 1:00 PM on ation revealed, that the t:		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.	

Facility ID: 00705

If continuation sheet Page 3 of 6

PRINTED: 12/31/2014

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	СОМ	PLETED
		245102	B. WING		11/1	19/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAUER H	HEALTH CARE			635 WEST SERVICE DRIVE NINONA, MN 55987		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 029	1. Basement - sout open penetration a	ge 3 h storage room (over 50 sq ft), round conduit east wall inen room door, will not shut	K 029	" Citation and plan for correctiv and ongoing prevention to be revi QA meeting on 1/13/2015.	ewed at	
	3. Basement - stora will not shut and lat 4. 1st floor - east w penetration where p	ing custodian room open bipe was removed		Compliance for adherence to this be the responsibility the Maintena Department Manager.		
K 033	Director of Mainten discovery.	ctices were confirmed by the ance (DM) at the time of FETY CODE STANDARD	K 033			1/4/15
SS=E	enclosed with cons resistance rating of arranged to provide and provide protect	uch as stairways) are truction having a fire at least one hour, are a continuous path of escape, tion against fire or smoke from uilding. 8.2.5.2, 19.3.1.1				
				: 		
	Based on observa facility failed to mai at least one hour in accordance with th 2000 NFPA 101, Se could effect 40 out	s not met as evidenced by: tion and staff interview, the ntain a fire resistance rating of the exit component e following requirements of ection 19.3.1.1, 8.2.5.2. This of 62 residents.		In response to the above stated of Sauer Health Care has taken the action: " The doors have been adjuste repaired to insure a positive latch " All open penetrations have be sealed with the appropriate mater	following d or een rial.	
	11/19/2014, observ	veen 9:30 AM and 1:00 PM on ation revealed that the d in the Basement - front		 Administrator attended resider council on 12/2/2014 and reviewer citations including this one. Education was provided to station-service training on 12/11/2014. 	ed aff at an	

Facility ID: 00705

If continuation sheet Page 4 of 6

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245102	B. WING	¥	11/1	9/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 033	Continued From pa stairwell: 1. Doors to classroo shut and latch, 2. Penetration arou	om and beauty shop will not	K 033	 will be trained on all plan of care information by 1/4/2015. " Citation and plan for correcti and ongoing prevention to be rev QA meeting on 1/13/2015. Compliance for adherence to this be the responsibility the Mainten 	viewed at s plan will	
K 062 SS=D	Facility Maintenanc discovery. NFPA 101 LIFE SA Required automatic continuously mainta condition and are ir	ctices were confirmed by the e Director (DM) at the time of FETY CODE STANDARD c sprinkler systems are ained in reliable operating aspected and tested .6, 4.6.12, NFPA 13, NFPA 25,	K 062	Department Manager.		1/4/15
	Based on observat facility failed to mai in accordance with NFPA 101, Sections 1998 NFPA 25, sec practice could affect Findings include: On facility tour betw 11/19/2014, observ basement floor - sp	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.5 and 9.7, as well as tion 2-4.1.4. This deficient at all 20 out of 62 residents.		In response to the above stated Sauer Health Care has taken the action: " An inventory of building sprin heads was made and any missin sprinkler heads were ordered to proper amounts of spare heads spare sprinkler head box. " Administrator attended resid council on 12/2/2014 and review citations including this one. " Education was provided to s in-service training on 12/11/2014 will be trained on all plan of care information by 1/4/2015. " Citation and plan for correcti	e following ukler ig insure the are in the ent ent ed taff at an . All staff	

Event ID: 27LG21

Facility ID: 00705

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245102	B. WING		<u>_</u>	11/1	9/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE		
SAUER	HEALTH CARE				VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	This deficient pract Facility Maintenanc discovery.	ice was confirmed by the e Director (DM) at the time of	K	062	and ongoing prevention to be review QA meeting on 1/13/2015. Compliance for adherence to this p be the responsibility the Maintenan Department Manager.	lan will	

Facility ID: 00705

If continuation sheet Page 6 of 6

PRINTED: 12/31/2014



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

Sauer Health Care December 15, 2014 Page 2

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, <u>Kathryn.serie@state.mn.us</u> 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,

Kumalu Fiske Downing

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 Sauer Health Care December 15, 2014 Page 3

Minnesc	ta Department of He	alth			-	-
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00705	B. WING		11/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00705	B. WING		11/	25/2014		
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		11/20/2014		
			ST SERVICE I					
DAUER		WINONA	, MN 55987					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 000	Continued From pa	age 1	2 000					
	you electronically. is necessary for St enter the word "con text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Departr On dates surver visited the above p correction orders a your electronic plan	yors of this Department's staff, rovider and the following ire issued. Please indicate in n of correction that you have lers, and identify the date wher						
	the State Licensing federal software. T	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for						
	column entitled "II statute/rule out of of "Summary Stateme and replaces the "" correction order. T findings which are after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.						
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		00705	B. WING		11/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 285	MN Rule 4658.0100 Orientation and In-S		2 285			
	must provide in-ser education must be continuing compete address areas iden assessment and as must address the s determined by the r home must provide program in rehabilit to promote ambulat living; assist in activ of range of motion,	education. A nursing home vice education. The in-service sufficient to ensure the ence of employees, must tified by the quality ssurance committee, and pecial needs of residents as nursing home staff. A nursing an in-service training ation for all nursing personnel ion; aid in activities of daily <i>v</i> ities, self-help, maintenance and proper chair and bed he prevention or reduction of				
	by: Based on interview facility failed to iden infections (UTI), mo monitor and analyze recurrent UTIs and staff education for 5 R20, R8 and R78) w infections and for th ((R19, R67, R25, R R64, R35, R31, R50	and document review the tify recurrent urinary tract onitor and tract symptoms, e data to minimize the risk of the facility failed to provide 5 of 5 residents (R51, R14, with recurrent urinary nese 17 additional residents 38, R5, R44, R59, R75, R12, 6, R55, R6, R87 & R999) ility on the infection logs October 2014.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	HEALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 285	Continued From pa	ige 3	2 285			
	Findings include:					
	April 24, 2014 and an indwelling cathe completed by the in R51 would display of possible UTI (beha blood pressure cha symptoms were ide was identified for th culture identified th	rinary tract infections between September 12, 2014. R51 had ter. Documentation ifection control nurse indicated one symptoms indicating a viors, confusion, agitation, nges). On two occasions 2 entified. The micro-organism aree of the infections and each e same micro-organism. Two were identified used for the sm.				
	June 2014 and Sep Documentation corn nurse indicated R14 of the infections. T documentation indi other infection docu symptoms had bee micro-organisms had infections. In June noted the culture re	npleted by the infection control 4 had displayed only falls for 2				
	case only one symp	rinary tract infections. In each otom was identified. In each organisms were identified for				
	or two symptoms w did not have an ide	nary tract infections. Only one vere identified. One infection ntified micro-organism and the tified two micro-organisms infection.				
	R78 developed 2 u	rinary tract infections. R78				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SAUER I	HEALTH CARE		T SERVICE I MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 285	identified for each in identified the micro- micro organisms). The infection contro- reviewed. The doct the number of ident not correspond to th non-catheter and 2 analysis provided for not identify trends of recurrent micro-org The facility policy en (UTI) Prevention an read, : 1. Do not treat asy to treat UTI without the following::a) fev on urination, freque pain d)change in ch of mental or functio 2. Do not treat asy to treat a UTI with a following: a) fever of change in character 22 other residents a episode of UTI during through October 20 nurse documentation lacked the 2 or 3 sy accordance with the control nurse docur of the micro-organis provided by the direct a repetition of micro-	theter. Two symptoms were infection, but only one infection organisms responsible (2 of nurse documentation was umentation did not note that ified symptoms present did ne policy (3 symptoms for symptoms if catheter). The or the quality committee did of recurrent UTIs of or anisms. Intitled Urinary Tract Infection and Management dated 2/3/09 ymptomatic UTI. Indications a catheter should have 3 of rer, b) increased burning, pain incy, or urgency, c)new flank haracter of urine, e) worsening nal status. Symptomatic UTI. Indications a catheter must have 2 of the or chills b) new flank pain, c)	2 285	DEFICIENC	Υ)	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING				
		00705	B. WING		11/2	25/2014	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
SAUER	HEALTH CARE		ST SERVICE D , MN 55987	DRIVE			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 285	Continued From pa	ge 5	2 285				
	symptoms listed, bu infection control num this resident. *May 2014. 7 U not identified above indicated only one s The micro-organism one symptom of ele an elevated white c noted. R38 had on as an indicator of a reported. R5 had o an indicator of a UT reported. R44 had as an indicator of a were identified. Review of the docu Proteus mirabilis, H E-coli were micro-o infections. *June 2014 6 U facility-2 not listed a infections. R59 wa acute lower UTI. N symptoms or cultur hospital discharge s documentation. R7 symptom documen	entified above. R19 had 3 at no culture results. The rse had not documented on JTIs identified by the facility-5 e. R67 had documentation tha symptoms (behavior change). In was identified. R25 had evated temperature and also ount. The culture results were ly one symptom documented UTI, no micro-organism was the symptom documented as T and no micro-organism was two symptoms documented UTI and 2 micro-organisms mentation provided indicated Klebsiella Pneumoniae, and rganisms identified by the as residents with multiple as admitted to the hospital with o information related to e results was identified on the summary or infection 75 had a catheter and had one ted as an indicator of a UTI s. Two micro-organisms were					
	identified for the mo not have micro-orga control nurse. *July 2014 4 U ⁻ facility-3 not listed a	mentation of the 6 UTIs onth three of the infections did anisms listed by the infection IIs were identified by the as residents with multiple UTIs and had one symptom					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING			
		00705	B. WING		11/25/2014	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUER	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 285	Continued From pa	age 6	2 285			
	control nurse. R64 with a diagnosis of nurse did not docu micro-organisms. identified indicating was identified. Re- provided indicated documented sympt and two lacked doc *August 2014 6 UT month-3 were not i recurrent UTIs. R3 indicating a UTI an R56 had two symp identified. R55 had micro-organism ide infection control nu only 4 of the 6 infect micro-organisms a organisms-E-Coli, Proteus Mirabilis. the symptoms iden facility policy. *September 2014 three residents ide multiple/recurrent U had no symptoms iden infection control do the reports had ind potential UTI and c micro-organisms. *October 2014 3 U identified as having symptoms identifie micro-organism list identified. Review	R35 had two symptoms g a UTI and a micro-organism view of the documentation that all 4 infections lacked toms as identified by the policy cumented micro-organism. TIs were identified for the dentified as residents with 31 had two symptoms id a micro-organism listed. toms and two micro-organisms one symptoms listed and no entified. Review of the urse documentation indicated ctions had identified nd three of the 4 had the same Klebsiella Pneumoniae, and Only one of the 6 residents had utified in accordance with the 4 UTIs identified by the facility-				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 285	Continued From pa	ge 7	2 285			
		anism identified-E-Coli and all ymptoms according to the				
	at 7:45 p.m. by the indicated this was t quality assurance (line listing did not in culture results, inte an interview on 11/2 indicated infections monthly to identify p on 11/21/14 at 2:00	ctions was provide on 11/17/14 director of nursing. She he information provided to the (QA) committee meeting. The include the resident name, rventions or resolution. During 29/14 the director of nursing were tracked on a map batterns. During an interview 0 p.m. the administrator stated and information was part of the ess.				
	director of nursing (urinary tract infection pattern. It had been residents with cather bacteria and that the decided that these have urine cultures counts to determine director of nursing i were necessary to collect a urine cultur order. The sympto asking the resident behavior, or past hi director of nursing i potential UTI, staff provide perineal ca hand washing. When reviewing the director of nursing of	on 11/25/14 at 10:44 a.m. the DON) indicated she felt the ons were being analyzed and in determined that the four eters would chronically have e medical director had residents would no longer but rather white blood cell e a possible infection. The ndicated only 2 symptoms determine a potential UTI and re as directed in the standing ms would be determined by , notifying changes in story. During the interview the ndicated if a resident had a were to encourage fluids, re, offer reminders, and good e infection reports with the on 11/25/14 at 2:30 p.m. she that residents with catheters				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - 11/25/2014	
		00705	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE I , MN 55987	DRIVE		
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2 285	Continued From pa	ge 8	2 285			
nnesota D	tracked: The facility's policy 12/12/13 indicated s in-service training of residents. The poli ongoing monitoring appropriate actions Guidelines to invest report disease and Tracking and trendi investigation, b)data infection, location, r community acquired compare rates over clusters, trends and improvement, d) mo in residents. During the interview director of nursing s dedicated to infection surance. DON in control nurse's resp implement infection reviews the reports qualify committee. director of nursing i monitor micro-orga antibiotics. She add infections, not antib The administrator w 2:00 p.m. She india would be present at committee meeting	antibiotic effectiveness not entitled Infection Control dated staff were to have appropriate on managing infections in cy also read, "Through this facility will take per State and Federal tigate, prevent, control and infection." The policy identified ng Infections: as a) a collection as to type of resident and facility or d, c) calculate the data and r time to identify pattern,				

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE D , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 285	and re-occurring inf and reviewed by the administrator stated the large number of nurse tracks the UT infection control nur educate staff on pe stated she had no of number of UTIs at p SUGGESTED MET The DON or design policies and proced staff education relat The Director of Nur education programs performance.	ections would be discussed e medical director. The d that she had not recognized f UTIs. The infection control TIs and infections. The rse would be responsible to rineal care. The administrator concerns related to the				
2 540	Resident Assessme Subpart 1. Assess conduct a compreh resident's needs, w capability to perform significant impairme nursing assessmen Minnesota Statutes 15, may be used as resident assessmen comprehensive res used to develop, re comprehensive plan 4658.0405. Subp. 2. Informa	o Subp. 1 & 2 Comprehensive ent ment. A nursing home must ensive assessment of each hich describes the resident's in daily life functions and ents in functional capacity. A t conducted according to , section 148.171, subdivision a part of the comprehensive int. The results of the ident assessment must be view, and revise the resident's in of care as defined in part ation gathered. The ident assessment must	2 540			

linnesota Department of He	alth				
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00705	B. WING		11/2	25/2014
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUER HEALTH CARE		ST SERVICE E MN 55987	DRIVE		
REFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 540 Continued From pa	ge 10	2 540			
 A. medically demedical history; B. medical stat C. physical and D. sensory and E. nutritional stat F. special treat G. mental and H. discharge p I. dental condit J. activities pot K. rehabilitation L. cognitive stat M. drug therapy N. resident prediction This MN Requirements by: Based on interview facility failed to com assessment to deter insomnia for 1 of 1 facility with a diagnorial asleep medication Findings include: R91 was not comprised in a solution of the state of the state	ion; ential; n potential; itus; r; and ferences. ent is not met as evidenced and document review, the nplete a comprehensive sleep ermine interventions to control resident (R91) admitted to the osis of insomnia and receiving rehensively assessed for to the Minimum Data Set I residents admitted to the to the facility 11/3/14 and had on the physician orders as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED	
		00705	B. WING		11/25/2014	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
SAUER H	HEALTH CARE		ST SERVICE	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	ge 11	2 540			
		ndicating minimal depression nosis of progressive				
	diazepam (Valium) Trazodone (antidep sleeping aide) at be note text dated 11/ medications, but die for sleep or interver without medication.	orders dated 11/3/14 for at bedtime for anxiety, and ressant used out of class as a edtime for insomnia The CAA 14/14 identified these d not include an assessment ntions to help R91 attain sleep The CAA list of factors that cerbate the behaviors did not bances.				
	identify a sleep dist symptoms/behavior	rehensive Nursing nission effect 11/3/14 did not urbance or behavior/mood 's or interventions for nnia or behavioral symptoms.				
	11/21/14 at 10:50 a necessary to look a insomnia and depre	RN)-B was interviewed on .m. RN-B stated it was not t the medications for anxiety, ession for 3 months according -B noted the facility monitored				
	director of nursing or responsible for ass	HOD OF CORRECTION: The could in-service all nurses essments of residents the the Minimum Data Set.	2			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 555	MN Rule 4658.0409 Plan of Care; Deve	5 Subp. 1 Comprehensive	2 555			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE WINONA, MN 55987 C(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED DE FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED DE FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED DE FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) 2 555 Continued From page 12 2 555 2 555 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after 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.	STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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 PRECOEDD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECOEDD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECOEDD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) 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 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 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. I			00705	B. WING		11/25/2014	
SAUER HEALTH CARE WINONA, MN 55987 Image: Construct of the state of the	NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for 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 the resident's medica diagnosis which includes medication use, diet and fluid restriction for 1 of 5 residents (R39) reviewed for unnecessary medications.	(X4) ID	SUMMARY STA		- 	PROVIDER'S PLAN OF C	ORRECTION	(X5)
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.					CROSS-REFERENCED TO TH	IE APPROPRIATE	COMPLET DATE
 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. 	2 555	Continued From pa	age 12	2 555			
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		must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the the resident's legal representative. This MN Requirem by: Based on observat review, the facility f related to monitorin related to the reside includes medication for 1 of 5 residents unnecessary medic Findings include: R39 was observed sitting in a wheelch wife stated R39 has months because sh at home. R39 was readmitte and had diagnoses dated 10/24/14 as of	mprehensive plan of care for in seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the i, a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen ent is not met as evidenced ion, interview and document ailed to develop a plan of care of for signs and symptoms ent's medical diagnosis which in use, diet and fluid restriction (R39) reviewed for cations. on 11/18/14 at 10:55 a.m. air with feet on floor. R39's d been in the facility for two ne was unable to care for him d to the facility on 10/24/14 listed on the physician orders chronic kidney disease, gout,				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SAUER I	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE			
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2 555	Continued From pa	age 13	2 555				
	anticoagulants, hyp dementia.	pertension, depression,					
	low sodium/low cho including aspirin ar hypertonicity of bla	ders included: fluid restriction, blesterol diet. Medications ad Coumadin, Detrol for dder, Flomax, for hypertrophy and Zestril diuretics for illure.					
	The care plan did r interventions to dire fluid restrictions, go bladder and prosta to identify incontine include the use of 0 for bleeding in whic	nted 11/21/14 was reviewed. not include problems or ect staff related to the diet and but, the use of medications for te issues or diuretic use excep ence. The care plan did not Coumadin and aspirin and risk ch the nursing aides need to be of bleeding or other symptoms te interventions.	t				
	Plans-Comprehens comprehensive car measurable objecti resident ' s medica	dated 3/3/14 entitled Care sive noted an "individualized re plan that includes ives and timetables to meet the I, nursing, mental and Is is developed for each	9				
	11/25/14 at 9:57 a. did not include pos medications for an	sing (DON) was interviewed or m. and verified the care plan sible side effects related to ticoagulants, high blood on, special diet and fluid					
	The Director of Nur develop, review, ar	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure Care Plans are developed					

Minnesc	ota Department of He	alth			FORM	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/25/2014	
		00705	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE I , MN 55987	DRIVE		
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2 555	Continued From pa	ge 14	2 555			
	for appropriate care medical issues.	e of the resident with multiple				
	educate all appropr procedures, and co	sing or designee could iate staff on the policies and uld develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	by: Based on observati review the facility fa personal hygiene fo	ent is not met as evidenced on, interview and document iled to follow the care plan for or nail care for 1 of 3 residents activities of daily living.				
	Findings include:					
	quarterly Minimum 10/30/14, identified	itted on 5/15/14. R31's Data Set (MDS) dated but not limited to diagnoses of red extensive assist of one I hygiene.				
	R31 had been in ro	on 11/18/14, at 10:17 a.m., om sitting in wheelchair. R31's ght hand had dark brown				

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2 565	Continued From pa	ige 15	2 565				
	fingernails. On 1/20 been in room sitting fingernails on her ri debris observed un fingernails. R31's care plan dat self-care deficit rela interventions of but dependent on one s extensive assist of During an observat nursing assistant (N fingernails on R31's clean residents fing during bathing and	derneath on four of the five 0/14 at 10:31 a.m., R31 had g in wheelchair. R31's 1ght hand had dark brown derneath the same four ted 6/24/14, identified problem ated to dementia with not limited to totally staff for bathing, needs one staff for personal hygiene. ion on 11/21/14 at 10:27 a.m., NA)-A verified the dirty s right hand. NA-A stated staff gernails on their bath days as needed. NA-A stated she cleaning R31's fingernails					
	registered nurse (R fingernails on R31's needed to be clean clean R31's fingern	ion on 11/21/14 at 10:28 a.m., N)-B verified the dirty s right hand and stated they ed. RN-B stated staff was to hails on her bath day and as ed R31 had her bath day on morning.					
	director of nursing s resident fingernails day and stated staf	on 11/21/14 at 10:44 a.m. the stated she expected all to be cleaned on their bath f should clean resident ed as a part of their daily					
	DON stated she co fingernails would be	on 11/21/14 at 11:30 a.m., the nsidered ensuring clean e included in providing one for personal hygiene and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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2 565	Continued From pa	ge 16	2 565			
	R31. A policy was r	an had not been followed for equested for following the e plan at this time and one				
	The director of nurs develop and implen to ensure that resid the plan of care; ed develop monitoring	ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures lents receive care according to lucate all relevant staff. Then systems to ensure ongoing port the findings to the Quality tee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document alled to revise the care plan to giene of shaving for 1 of 1				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 17	2 570			
	residents (R65) with long facial hair.					
	Findings include:					
		on 11/18/14 at 9:00 a.m. and m. with long facial hair on her				
	indicated R65 requ one staff with perso dated 10/21/14 indi perform some of he following staff assis	im Data Set dated 10/21/14 ired extensive assistance of onal hygiene. The care plan icated R65 was able to er own personal hygiene stance with set up. The care e if R65 needed assistance aining a razor.				
	required assist of o	ant flow sheet indicated R65 one with activities of daily living. not indicate the need for ir.				
	Plans-comprehens Planning/Interdiscip	ated 3/3/14 entitled Care ive read, "The Care blinary Team is responsible for ating of care plans."				
	11/25/13 at 10:03 a	sing (DON) was interviewed on a.m. DON stated care plan and ow sheet should address the				
	The Director of Nur develop, review, an procedures to ensu- needed to provide to	THOD OF CORRECTION: rsing or designee could ad/or revise policies and ure Care Plans are revised as for appropriate care of the ole medical issues.				
		rsing or designee could				
ATE FOR	epartment of Health M		6899 27	7LG11	If continuati	on sheet 18 c

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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SAUER I	HEALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ge 18	2 570			
	procedures, and co	iate staff on the policies and uld develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 850	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 D Adequate and e; Shaving	2 850			
	proper care. The c adequate and prop D. Assistance	or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to include facial hair ent request for 1 of 1 resident h facial hair.				
	Findings include:					
	long facial hair on h she would generally the razor was dull. about an inch in len R65 was observed and neck. The resi have it again" in reg long chin hair. R65 razor and she would	on 11/18/14 at 9:00 a.m. with her chin and neck. R65 stated y have them shaved, but that The facial hair was gray and ngth. On 11/25/14 at 9:40 a.m. to have facial hair on the chin ident commented "Oh do I gards to the question about the s stated staff use their own d forget to tell them to shave pothered her if the facial hair				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		20/2014
SAUER I	HEALTH CARE		ST SERVICE D A, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 850	Continued From pa	age 19	2 850			
	indicated R65 required action on the staff with person dated 10/21/14 indiger form some of here following staff assist nursing assistant fl required assist of convertient the care plain dicate the need for the director of nursing 11/25/13 at 10:03 at 10:0	Im Data Set dated 10/21/14 ired extensive assistance of onal hygiene. The care plan icated R65 was able to er own personal hygiene stance with set up. The ow sheet indicated R65 one with activities of daily living an or flow sheet did not or shaving of facial hair. sing (DON) was interviewed or a.m. and stated the nursing have a resident shaved as par es.	n			
	The director of nurs in-service all staff of living including sha of nursing or desig monitor for complia		r			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 860	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			
	proper care. The c adequate and prop E. per care and at	or determining adequate and criteria for determining er care include: tention to hands and feet. enails must be kept clean and				
	This MN Requirem	ent is not met as evidenced				

STATE FORM

27LG11

If continuation sheet 20 of 50

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/25/2014	
		00705	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE D ., MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 860	by: Based on observati review the facility fa of 3 residents (R31 living. Findings include: R31 had been adm quarterly Minimum 10/30/14, identified of dementia, depres assist of one perso During observation R31 had been in ro fingernails on her ri debris observed un During an observat R31 had been in ro fingernails on her ri debris observed un fingernails. R31's care plan dat self-care deficit rela interventions of but dependent on one s extensive assist of During an observat nursing assistant (N fingernails on R31's clean residents fing during bathing and	ge 20 on, interview and document ailed to ensure clean nails for 1) reviewed for activities of daily itted on 5/15/14. R31's Data Set (MDS) dated d but not limited to diagnoses ssion and required extensive n for personal hygiene. on 11/18/14, at 10:17 a.m., om sitting in wheelchair. R31's ght hand had dark brown derneath four fingernails. ion on 11/20/14 at 10:31 a.m., om sitting in wheelchair. R31's ght hand had dark brown derneath the same four end 6/24/14, identified problem ated to dementia with not limited to totally staff for bathing, needs one staff for personal hygiene. ion on 11/21/14 at 10:27 a.m., NA)-A verified the dirty s right hand. NA-A stated staff gernails on their bath days as needed. NA-A stated she cleaning R31's fingernails				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 860	registered nurse (R fingernails on R31's needed to be clean clean R31's fingern needed. RN-B state Wednesday in the During an interview director of nursing s resident fingernails day and stated staf fingernails as need cares. The Nail Care of (F 2/3/09 read, "Resid and toe nails will be SUGGESTED MET The director of nurs in-service all staff of living including fing director of nursing of audits to monitor for	N)-B verified the dirty sight hand and stated they ed. RN-B stated staff was to ails on her bath day and as ed R31 had her bath day on morning. on 11/21/14 at 10:44 a.m. the stated she expected all to be cleaned on their bath f should clean resident ed as a part of their daily inger and Toe) policy dated ent's unable to care for finger assisted as needed." THOD OF CORRECTION: sing or designee could on performing activities of daily er nail care for residents. The por designee could schedule				
2 910	Incontinence Subp. 5. Incontine have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ing catheter is not catheterized	2 910			

STATEMEN	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE E A, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	Continued From page 22 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.				
	by: Based on interview facility failed to con tract infection (UTI) individualized plan	ent is not met as evidenced and document review, the hprehensively assess urinary) risk and develop an of care for 5 of 5 residents 8, R20) with a history of act infections.				
	R51 developed urir 5/13/14, 6/27/14, 8 9/13/14 R51 was d to gram negative o infection resulting i intravenous antibio history and physica had been admitted septic shock with E complicated UTI in (history and physic	hary tract infections on 4/24/14 /29/14, and 9/12/14. On iagnosed with Septicemia due rganism and urinary tract n hospitalization and tics. Review of the hospital at (H & P) dated 9/13/14 R51 to the hospital related to coli bacteremia from a January 2014. The H & P al) indicated R51 had also mergency room on 8/26/14 n a UTI.				
	was reviewed. R52 related to septic sh stated R51 was dis	y and physical dated 9/13/14 2 was admitted to the hospital lock secondary to infection and splaying signs of end organ shock. The H & P indicated	1			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE E , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 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.					
	for R51 dated 11/12 reviewed. The ass bladder screener in of bladder and stoo medical issues incl catheter and a histo assessment lacked for developing urina contributing factors contributing factors medical conditions, medications, physic R51's plan of care p focus of " was hos bacteremia, history staphylococcus aur practitioner on 3/25 colonized, and had to prostate cancer. staff to change the signs of a UTI. The	rehensive nursing assessment 2/14 was provided and essment noted a bowel and dicated R51 was incontinent al, had terminal end stage uding prostate cancer, had a pry of frequent UTIs, The l identification of risk factors ary tract infections, such as related to catheter use, or co-morbidity related to cognitive function, cal function or environment. printed 11/25/14 included a pitalized with urosepsis with of MRSA (methylene resistant reus) in urine that the nurse f/14 noted R51 was likely an in dwelling catheter related The interventions directed catheter and observed for e interventions did not provide es to help minimize the risk of				
	7/17/14, 8/14/14, 9/	hary tract infections on 6/9/14, /12/14 and lacked vent more UTIs from				
	dated 9/23/14 note bladder, predisposi and a bowel ostom	Tehensive nursing assessment d infrequent incontinence of ng factors for incontinence y. The assessment lacked factors for developing urinary				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00705	B. WING		11/	25/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	HEALTH CARE		ST SERVICE D , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 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.					
	6/16/14. On 6/12/ with C-Diff (Clostric dif-uh-SEEL), often	hary tract infections on 5/2/14, 14 R78 was also diagnosed lium difficile (klos-TRID-e-um called C. difficile or C. diff) to the infection control log.				
	dated 9/17/14 indic incontinent, had a contract of the occasionally leak. identification of risk tract infections, succontract of the occasional of the occasional of the occasional of the occasion of the oc	rehensive nursing assessment ated R78 was occasionally catheter that would The assessment lacked a factors for developing urinary ch as contributing factors use, contributing factors or d to medical conditions, medications, or assessments d lead to septicemia and				
	indicated a diagnost chronic indwelling of directed staff to cha for signs of a UTI.	n printed 11/25/14 that sis of neurogenic bladder and catheter. The interventions ange the catheter and observe The interventions did not pproaches to help minimize t UTIs.				
		ary tract infections on 6/15/14, d interventions to reduce UTIs				
	The comprehensive	e nursing assessment dated				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE D ., MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 25	2 910			
	of bowel and bladd predisposing incon assessment lacked for developing urina contributing factors medical conditions, medications. The plan of care pr longstanding histor urgency and direct urinary tract infection provide staff with a the risk of recurren R20 developed urin	3 was occasionally incontinent er and had no untreatable tinence risk factors. The d identification of risk factors ary tract infections, such as s or co-morbidity related to , cognitive function, inted 11/25/14 indicated a y of urinary frequency and ed staff to monitor for signs of ons. The interventions did not pproaches to help minimize t UTIs.	,			
	9/12/14 indicated R incontinent, was ind had no predisposin The assessment la factors for develop such as contributin related to medical of	e nursing assessment dated 20 was occasionally dependent with toileting and og factors for incontinence. Icked identification of risk ing urinary tract infections, g factors or co-morbidity conditions, cognitive function, cal function or environment.				
	longstanding diagn interventions to ide interventions did no	inted 11/25/14 had a focus of osis of stress incontinence and ntify signs of UTI. The ot provide staff with o minimize the risk of recurrent				
	11/25/14 at 2:30 p.	sing was interviewed on m. She indicated the rsing assessments and care				
Minneso	ta Department of He	alth			FORM	APPROVED
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/2	25/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
SAUER H	HEALTH CARE		ST SERVICE I , MN 55987	DRIVE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
2 910	Continued From pa	ge 26	2 910			
	stated no other ass tract infection risks	ed on each resident. She essments related to urinary or individualized care plans to recurrent infections had been				
	(UTI) Prevention ar did not direct nursin for the risk of devel and did not direct th individualized care	ntitled Urinary Tract Infection ad Management dated 2/3/09 ng staff to assess a resident oping urinary tract infections ne development of an plan to assist staff with minimize the risk of recurrent ons.				
	The director of nurs employees respons tract infections on t	HOD OF CORRECTION: sing could inservice all sible for preventing urinary he need to assess and hs to prevent urinary tract				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sai) Subp. 7 Dietary Staff hitary conditi	21015			
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview, and document ailed to ensure refrigerator alk in coolers was maintained				

	NT OF DEFICIENCIES					E SURVEY PLETED
		00705	B. WING		11/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	in a clean and sanit potential to affect al that had been provi distributed from the Finding Include: During the initial kitu p.m., with cook (C)- was observed to ha spots, hanging clum in varying colors of second walk-in cool out of 23 shelves of clumps, and fuzzy a colors of gray, gree On 11/17/14 at 6:17 identified shelves in with spots, hanging debris in varying co Cook-A verified the the floors of the wal cleaned on Wedness schedule did not ind the walk-in coolers. During a kitchen ob p.m., with another s dietary manager (C identified shelves in the fifteen identified cooler had areas wi fuzzy areas of debri green and black. Th concern on the iden coolers were mold. shelving in the walk	ary manner. This had the I 62 residents in the facility ded food prepared and facility kitchen. chen tour on 11/17/14, at 6:10 A the walk-in dairy cooler we 6 out of 18 shelves with hps, and fuzzy areas of debris gray, green and black. The ler was observed to have 15 oserved with spots, hanging areas of debris in varying n and black. Y p.m. C-A verified the the walk-in coolers had areas clumps, and fuzzy areas of lors of gray, green and black. cleaning schedule indicated k-in coolers were to be sdays and verified the cleaning clude cleaning the shelving in		DEFICIENC	27)	

	epartment of He DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00705	B. WING		11/2	11/25/2014	
AME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
AUER HEAL	TH CARE		ST SERVICE [MN 55987	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21015 Cor	ntinued From pa	ge 28	21015				
adr clea the not wal Dun the wal clea The bee stat of it aba last on the in b she Sar rec she app the The mo awa stat hap not	ninistrator stated aned. The admir policy and verifi specifically list of k-in coolers. Ting a kitchen ob CDM on 11/18/ k-in cooler was aned and had ei e second walk-ir en cleaned and had ei e second walk-ir nooler was ts condition. The tement contract inght by mainte how to clean the mold concern. Tooth walk-in cool elves, the walls a notracin RTU, a completed aud barently not well shelves in the w e CDM stated sh rning and discus are of cleanlines ted, "I don't know opened. There is have happened	on 11/18/14, at 7:45 a.m., the d the refrigerators have been histrator stated she reviewed ed the policy/procedure does cleaning of the shelves in the beervation and interview with 14, at 8:47 a.m., the dairy observed to have been ghteen shelves in the cooler. In cooler was observed to have had only 16 out of the 23 erved in the cooler. The CDM shelving from the second going to be replaced because a CDM stated Asbesbegon (an tor) company was contacted mance for a recommendation a walk-in coolers because of The CDM stated the shelving ers was power washed, all the and flooring was cleaned with mold killing chemical asbesbegon. The CDM stated its of the kitchen areas but enough because the mold on walk-in coolers was missed. he had a staff meeting this ased the need for staff to be as in the kitchen. The CDM w what to say. I am upset this a nothing I can say. It should I." The CDM stated all kitchen cated on maintaining a clean					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING		11/25/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	IEALTH CARE		T SERVICE D MN 55987	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21015	Continued From pa	ge 29	21015			
	documentation of tr illness in the kitcher between staff illnes mold found in the k The General Sanita 12-7-11 read, "The maintain the sanitat compliance with a v cleaning schedule. Procedure: 1. Cleaning and sar will be recorded. 2. Tasks will be ass of specific positions 3. Tasks will be add cleaning. 4. A cleaning schedul	(DON) stated she reviewed the racking and trending of staff in and there was no correlation is that can be related to the itchen walk-in coolers. Attion of Kitchen policy dated Dietary Services staff shall tion of the kitchen through written, comprehensive hitation tasks for the kitchen igned to be the responsibility is per cleaning schedule. Aressed as to frequency of lule will be posted and al and date tasks when				
	The director of nurs manager (CDM) an develop/review/ rev and provide educat sanitation and clear and food storage an designee could edu the policies/procedu ongoing compliance	THOD FOR CORRECTION: sing (DON) certified dietary id/or designee could ise policies and procedures ion for staff related to hing of the food refrigerators reas. The DON, CDM or licate all appropriate staff on ures, and monitor to ensure e.				
	days.		0.4655			
21390	MN Rule 4658.0800	0 Subp. 4 A-I Infection Control	21390			

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
			ST SERVICE I			
SAUER	HEALTH CARE	WINONA	, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21390	Continued From pa	ge 30	21390			
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for Products which affe disinfectants, antise incontinence produ I. methods for current standards of This MN Requireme by: Based on interview facility failed to iden infections (UTI), mo monitor and analyze	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of oct infection control, such as eptics, gloves, and cts; and maintaining awareness of f practice in infection control. ent is not met as evidenced and document review the utify recurrent urinary tract ponitor and tract symptoms, e data to minimize the risk of the facility failed to provide				
innocata D	R20, R8 and R78)	5 of 5 residents (R51, R14, with recurrent urinary nese 17 additional residents				

Minnesota Department of Health STATE FORM

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If continuation sheet 31 of 50

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00705	B. WING		11/2	11/25/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
SAUER H	IEALTH CARE		ST SERVICE [, MN 55987	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	ge 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:						
	April 24, 2014 and 3 an indwelling cathe completed by the in R51 would display of possible UTI (behat blood pressure chat symptoms were ide was identified for the culture identified the different antibiotics same micro-organis						
	June 2014 and Sep Documentation com nurse indicated R14 of the infections. T documentation indi- other infection docu symptoms had bee micro-organisms had infections. In June noted the culture re	npleted by the infection control 4 had displayed only falls for 2					
	case only one symp	rinary tract infections. In each otom was identified. In each organisms were identified for					
		nary tract infections. Only one vere identified. One infection					

	ta Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING		11/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE I MN 55987	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
21390	Continued From pa	ge 32	21390			
		ntified micro-organism and the tified two micro-organisms infection.				
	had a indwelling ca identified for each i	rinary tract infections. R78 theter. Two symptoms were nfection, but only one infection -organisms responsible (2				
	reviewed. The doc the number of ident not correspond to th non-catheter and 2 analysis provided for	ol nurse documentation was umentation did not note that tified symptoms present did he policy (3 symptoms for symptoms if catheter). The or the quality committee did of recurrent UTIs of or anisms.				
	(UTI) Prevention ar read, : 1. Do not treat asy to treat UTI without the following::a) fev on urination, freque pain d)change in ch of mental or functio 2. Do not treat asy to treat a UTI with a	symptomatic UTI. Indications a catheter must have 2 of the or chills b) new flank pain, c)				
	episode of UTI duri through October 20 nurse documentatio lacked the 2 or 3 sy accordance with the	also had developed a single ng the time period of April 14. The infection control on was reviewed. The reports mptoms identified in e policy and the infection mentation lacked identification				

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED	
		00705	B. WING		11/2	11/25/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
		1635 WE	ST SERVICE D	DRIVE			
SAUER F	IEALTH CARE	WINONA	, MN 55987				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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21390	Continued From pa	-	21390				
		sm. The analysis of data					
		ector of nursing did not indicate)				
		o-organisms between					
	residents with infec	tions 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						
		rse had not documented on					
	this resident.						
		JTIs identified by the facility-5					
		e. R67 had documentation that	t				
	indicated only one s	symptoms (behavior change).					
	The micro-organism	n was identified. R25 had					
	one symptom of ele	evated temperature and also					
	an elevated white c	ount. The culture results were	•				
		ly one symptom documented					
		UTI, no micro-organism was					
		ne symptom documented as					
		I and no micro-organism was					
		two symptoms documented					
		UTI and 2 micro-organisms					
	were identified.						
		mentation provided indicated					
		Klebsiella Pneumoniae, and					
		rganisms identified in 4 of the					
	infections.	IT lo wore identified by the					
		ITIs were identified by the					
		as residents with multiple as admitted to the hospital with					
		o information related to					
		e results was identified on the					
		summary or infection					
		75 had a catheter and had one					
		ted as an indicator of a UTI					
	, ,	s. Two micro-organisms were					
	identified.						
		mentation of the 6 UTIs					
			II			1	
	identified for the mo	onth three of the infections did					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00705	B. WING		11/	11/25/2014	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
HEALTH CARE			DRIVE			
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	ge 34	21390				
facility-3 not listed a R12 had a catheter identified as an indi micro-organism wa control nurse. R64 with a diagnosis of nurse did not docur micro-organisms. F identified indicating was identified. Rev provided indicated to documented sympt and two lacked doc *August 2014 6 UT month-3 were not id recurrent UTIs. R3 indicating a UTI and R56 had two sympt identified. R55 had micro-organism ide infection control nur only 4 of the 6 infect micro-organisms ar organisms-E-Coli, F Proteus Mirabilis. C the symptoms identification facility policy. *September 2014 4 three residents ident micro-organisms id infection control doo the reports had indi potential UTI and o micro-organisms.	as residents with multiple UTIs. and had one symptom cator or a UTI. No s identified by the infection was admitted to the hospital UTI. The infection control nent symptoms or R35 had two symptoms a UTI and a micro-organism riew of the documentation that all 4 infections lacked oms as identified by the policy umented micro-organism. Ts were identified for the dentified as residents with 1 had two symptoms d a micro-organism listed. oms and two micro-organisms one symptoms listed and no ntified. Review of the rse documentation indicated tions had identified nd three of the 4 had the same (lebsiella Pneumoniae, and Dnly one of the 6 residents had tified in accordance with the 4 UTIs identified by the facility- ntified as having UTIs and are listed above. R6 ndicating a UTI listed but had entified. Review of the cumentation indicated one of cated symptoms identifying a nly two had identified					
	PROVIDER OR SUPPLIER HEALTH CARE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From par control nurse. *July 2014 4 UT facility-3 not listed a R12 had a catheter identified as an indi micro-organism wa control nurse. R64 with a diagnosis of nurse did not docur micro-organisms. Fi identified indicating was identified. Rev provided indicated for documented sympt and two lacked doce *August 2014 6 UT month-3 were not id recurrent UTIs. R3 indicating a UTI and R56 had two sympt identified. R55 had micro-organisms ar organisms-E-Coli, F Proteus Mirabilis. O the symptoms identified. Proteus Mirabilis. O the symptoms identified. three residents ider multiple/recurrent LI had no symptoms id micro-organisms id infection control doc the reports had indi potential UTI and o micro-organisms.	OF CORRECTION IDENTIFICATION NUMBER: 00705 00705 PROVIDER OR SUPPLIER STREET ALE HEALTH CARE 1635 WE3 WINONA, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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-organism. R35 had two symptoms identified indicating a UTI and a micro-organism. *August 2014 6 UTIs were 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 as having multiple/recurrent UTIs and are listed above. R6 had no symptoms identified as having multiple/recurrent UTIs and are listed above. R6 had no symptoms identified. Review of the infection control documentation indicated one of the reports had indicated symptoms identifying a potential UTI and only two had identified	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: IDENTIFICATION NUMBER: B. WING	AT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIERCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: DO705 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TEALTH CARE 1635 WEST SERVICE DRIVE WINONA, MN 55987 VEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PROVIDER S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCE OF DEFICIENCY CONSTRUCTION OR LSC DENTIFYING INFORMATION) 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 . Review of the documentation provided indicating a UTI and a micro-organism was identified as residents with recurrent UTIs. R31 had two symptoms indicating a UTI and a 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-organisms identified. Review of the 6 infection shal identified only 4 of the 6 infection shal identified same organisms. Houring a two symptoms listed. R56 had two symptoms and two micro-organisms identified. Review of the infection control nurse documentation indicated only 4 of the 6 infections had identified micro-organism identified as residents had the symptoms identified as having multiple/recurrent	OF DEFICIENCIES OF CORRECTION (N1) PROVIDERSUPPLIERCILA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING: (X3) DATA A BUILDING: OF CORRECTION 00705 B. WING 11/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11// FEALTH CARE 1635 WEST SERVICE DRIVE PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST PROCEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST PROCEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST PROCEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST PROCEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST BALL OF CORRECTION (EACH OFCINCY MUST BALL OF CORRECTION (EACH OFCINCY MUST BALL OF CORRECTION (EACH OFCINCY ON LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST BALL OF CORRECTION (EACH OFCINCY ON LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH OFCINCY MUST BALL (EACH OFCINCY MUST BALL OF CORRECTION (EACH OFCINCY MUST BALL O	

STATEMEN	a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/	25/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	EALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	micro-organism liste identified indicating identified. Review documentation indic the same micro-org lacked identifying sy policy. A line listing of infect at 7:45 p.m. by the indicated this was th quality assurance (line listing did not in culture results, inter an interview on 11/2 indicated infections monthly to identify p on 11/21/14 at 2:00 the infection rate an QA committee proc During an interview director of nursing (urinary tract infection pattern. It had been residents with cather bacteria and that th decided that these in have urine cultures counts to determine director of nursing i were necessary to co collect a urine cultu order. The sympton asking the resident, behavior, or past his director of nursing i	d indicating a UTI and a ed. R999 had one symptom a UTI and micro-organism of the infection control cated two of the 3 UTIs had anism identified-E-Coli and all ymptoms according to the etions was provide on 11/17/14 director of nursing. She he information provided to the QA) committee meeting. The clude the resident name, ventions or resolution. During 29/14 the director of nursing were tracked on a map patterns. During an interview 0 p.m. the administrator stated ad information was part of the		DEFICIENC	~1)	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING	B. WING		25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	HEALTH CARE	1635 WE	ST SERVICE D	DRIVE		
SAUER		WINONA	, MN 55987			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21390	hand washing. When reviewing the director of nursing of stated she realized were having recurrent that other residents Lack of monitoring a tracked: The facility's policy of 12/12/13 indicated s in-service training of residents. The polic ongoing monitoring appropriate actions Guidelines to invest report disease and Tracking and trendi investigation, b)data infection, location, r community acquired compare rates over clusters, trends and improvement, d) mo in residents. During the interview director of nursing s dedicated to infection control nurse's resp implement infection reviews the reports qualify committee. director was very in control program and During an interview	e infection reports with the on 11/25/14 at 2:30 p.m. she that residents with catheters ent UTIs, but did not realize were also. antibiotic effectiveness not entitled Infection Control dated staff were to have appropriate n managing infections in cy also read, "Through this facility will take per State and Federal ligate, prevent, control and infection." The policy identified infections: as a) a collection as to type of esident and facility or d, c) calculate the data and time to identify pattern,				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00705	B. WING		11/	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE [, MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	The administrator w 2:00 p.m. She indic would be present at committee meeting meeting. The infect and re-occurring inf and reviewed by the administrator stated the large number of nurse tracks the UT infection control nur educate staff on pe stated she had no of number of UTIs at p SUGGESTED MET The administrator of in-service all emplo control practices to spread of infection.	vas interviewed on 11/21/14 at cated the medical director t the quality assurance and had input into the tion control list of infections fections would be discussed e medical director. The d that she had not recognized f UTIs. The infection control TIs and infections. The rse would be responsible to rineal care. The administrator concerns related to the bresent. THOD OF CORRECTION: or director of nursing could yees on the basics of infection reduce and prevent the				
21426	Prevention And Cor (a) A nursing home maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees,	A.04 Subd. 4 Tuberculosis htrol e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of	21426			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/2	25/2014
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE D A, MN 55987	DRIVE		
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21426	Continued From pa	age 38	21426			
		e technical assistance ntation of the guidelines.				
	(b) Written complia be maintained by th	ance with this subdivision mus ne nursing home.	t			
	by: Based on interview facility failed to ensi- that worked directly the two-step (two T each other) tuberco employees (EE-A)	ent is not met as evidenced y and document review, the sure newly hired employees y with residents had received B skin tests a few weeks from ulin skin test (TST) for 1 of 6 hired in the past 4 months and provide annual tuberculosis n training.				
	Findings include:					
	received a TST at t nursing student. T	10/13/14. On 9/19/14 EE-A the clinic because she was a he facility failed to ensure the second TST either from or facility.				
	(DON) was intervie received step one a documentation of t unable to find any o	5 a.m. the director of nursing wed. DON stated EE-A had at school, but there was no he second step and DON was documentation related to EE-A step before working with the				
	Assessment Treatr	lated 12/12/13 entitled Tb Risk ment and Prevention Plan es will receive baseline two				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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21426	Continued From pa	ge 39	21426			
	step Tb screening u	upon hire."				
	minutes of tubercul on 4/11/13. There w provided concernin need for TB training training occurred fo training. The goals/ training was on pro During an interview director of nursing s	e training showed that 5 osis education was conducted vas no current information g the annual evaluation of the g by the facility or if actual illowing the 4/11/13 TB objectives indicated the vision and reading of TST. o on 11/25/14 at 10:30 a.m. the stated the facility had not ining of the tuberculosis ention plan.				
	The DON (Director one staff to be in ch tuberculin skin test upon hire. The DO audits to ensure co addition the directo review/revise the tu prevention plan to i all aspects of tuber and prevention. Th	berculosis treatment and nclude annual staff training on culosis care, management, le DON or designee could on and monitor staff				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			
	residents have the	us treatment. Patients and right to be treated with ct for their individuality by				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00705	B. WING		11/	11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
SAUER I	HEALTH CARE		ST SERVICE I , MN 55987	DRIVE			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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21805	Continued From pa	ige 40	21805				
	employees of or pe health care facility.	employees of or persons providing service in a health care facility.					
	by:	ent is not met as evidenced					
	review, the facility	ailed to ensure a dignified or 2 of 2 residents (R27, R37) o dining room and required					
	Findings include:						
	experience on 11/1 and R30 were seat the same dining roc (NA)-B sitting in a c a.m. NA-B was obs side of R37 and as At 8:22 a.m. NA-B and assisted her to NA-B was observed was assisting R27 a observed to pour an adjacent table a cu returned to sit by R to eat. At 8:30 a.m. standing by R37 as a.m. NA-B was obs side of R37 assistin and take drinks of h	observed during a dining 8/14 starting at 8:12 a.m. R27 ed across from one another at om table with nursing assistant chair to right of R27. At 8:21 served to be standing by the sisting her to eat bites of food. sat down in the chair by R27 eat her food. At 8:23 a.m. d to leave the table where he and R37 to eat and was nother resident sitting at an p of coffee. At 8:25 a.m. NA-B 27 and resumed assisting her NA-B was observed to be sisting her to eat. At 8:33 served to be standing by the ng her to eat bites of her food ner fluids. At 8:35 a.m. NA-B e sitting down in the chair by to eat her breakfast.					
	NA-D verified he wa assisted her to eat	on 11/18/14 at 12:26 p.m. as standing by R37 when he her breakfast. NA-D stated that only ate a few bites of					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		1635 WE	ST SERVICE D	DRIVE		
SAUER	HEALTH CARE	WINONA,	MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From pa	ge 41	21805			
	down by her. NA-D because if he did no R27 became agitate somebody else and there were usually t this table during me two staff members residents that sat by stated R27 stopped meal as he had got was assisting her to R27's nutritional can the potential to be a diagnosis as well as meals Intervention meals" The active dated 11/2/12 read, for all of her ADL'S is a normal progress dementia. Intervent totally dependent on eating." The quarter assessment dated required extensive a nutritional assessm "FEEDING: Exter eating or drinking." R37's nutritional can the potential to be a advanced dementia therapeutic diet as diet consistency pe well as varying intal					
	and then assist with	urage [R37] to feed herself, feeding when resident does The activity of daily living				

					- (X3) DATE SURVEY COMPLETED	
		00705	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE E , MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	care plan dated 9/1 [activity of daily livin Deficit r/t [related to decreased function, requiring staff assis Interventions:req one staff with her mencouragement to of to be fed (total) as a to do with the silver days." The quarterly assessment dated required extensive nutritional assessm "FEEDING: Able assisted in the dinin During an interview director of nursing as seated next to resid assisting them to eaverified it was a dig resident and assist The Feeding a Dep 11/6/13 read, "6. Te going to be seated position a chair whe both them and the next SUGGESTED MET The director of nursing satistic to develop syste assisted to eat or fe quality assessment	9/14 read, " has an ADL ng] Self Care Performance o] impaired cognition and al status m/b [may be] stance with all ADLs uures extensive assistance of neals. She needs eat and will sometimes need she seems not to know what ware on certain, less aware, y Minimum Data Set (MDS) 10/28/14 indicated R37 assist of 1 staff for eating. The nent dated 6/25/14 read, to feed herself Summaryis ng room with meals." o on 11/20/14 at 2:34 p.m., the stated she expected staff to be dents in the dining room when at their meals. The DON nity issue to stand by a them to eat their meal.		DEFICIENC	ΥΥ) 	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	IEALTH CARE		ST SERVICE D , MN 55987	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
21805	Continued From pa	ge 43	21805			
	Twenty-one (21) day	ys.				
21830	MN St. Statute 144. Residents of HC Fa	651 Subd. 10 Patients & c.Bill of Rights	21830			
	Subd. 10. Particip notification of family	ation in planning treatment; v members.				
	in the planning of the includes the opportu- alternatives with ind opportunity to reque- care conferences, a	I have the right to participate bein health care. This right unity to discuss treatment and lividual caregivers, the est and participate in formal and the right to include a ther chosen representative or				
	both. In the event the present, a family me chosen by the reside conferences.	hat the resident cannot be ember or other representative ent may be included in such who enters a facility is				
	unconscious or com communicate, the fa efforts as required u	natose or is unable to acility shall make reasonable under paragraph (c) to notify				
	writing by the reside an emergency that admitted to the facil	ber or a person designated in ent as the person to contact in the resident has been ity. The facility shall allow the				
	planning, unless the to believe the reside	articipate in treatment e facility knows or has reason ent has an effective advance rary or knows the resident has	5			
	member included in notifying a family m	hat they do not want a family treatment planning. After ember but prior to allowing a				
	planning, the facility efforts, consistent w	articipate in treatment must make reasonable vith reasonable medical ne if the resident has				
		ce directive relative to the				

	ta Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00705	B. WING		11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SALIER I	HEALTH CARE	1635 WE	ST SERVICE	DRIVE		
OAUERI		WINONA	, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
				DEFICIENC	, T)	
21830	Continued From pa	ige 44	21830			
	esident's health car	re decisions. For purposes of				
		asonable efforts" include:				
		e personal effects of the				
	resident;	•				
	(2) examining the	e medical records of the				
		session of the facility;				
		ny emergency contact or				
		tacted under this section				
		nt has executed an advance her the resident has a				
		the resident normally goes for				
	care; and	the resident normally goes for				
		(4) inquiring of the physician to whom the				
		esident normally goes for care, if known,				
		nt has executed an advance				
	directive. If a facilit	directive. If a facility notifies a family member or				
		ency contact or allows a family				
		ate in treatment planning in				
		is paragraph, the facility is not				
		r damages on the grounds that				
		ne family member or				
		s improper or violated the				
	patient's privacy rig					
		asonable efforts to notify a				
		lesignated emergency contact,				
		empt to identify family				
		gnated emergency contact by				
		onal effects of the resident				
		cords of the resident in the				
		acility. If the facility is unable				
		ember or designated				
		within 24 hours after the lity shall notify the county				
		cy or local law enforcement				
		ident has been admitted and				
		n unable to notify a family				
		ated emergency contact. The				
		ce agency and local law				

Minneso	ota Department of He	alth			FORM	APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			20/2014
			ST SERVICE I			
SAUER	HEALTH CARE		, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21830	Continued From pa	ge 45	21830			
	identifying and notif designated emerge service agency or lo that assists a facility subdivision is not lia damages on the gro the family member	ey shall assist the facility in ying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper ent's privacy rights.				
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide choices regarding bathing residents (R70) reviewed for				
	Findings Include:					
	10/9/14, identified b Aphasia (unable to cerebrovascular ac required physical he person physical ass	num Data Set (MDS) dated but not limited to diagnoses of communicate accurately), cident, atrial fibrillation and elp in part of bathing of one sist. R70's brief interview for S) score of twelve indicated impairment.				
	" has an actual se CVA [cerebrovascu hemiplegiaInterv assistance of one fe do some tasks, but is not functioning de	(POC) dated 8/6/2014, read, elf-care deficit as related to his lar accident] with right sided entionsneeds the extensive or bathing. He may be able to limited as his dominant hand ue to his CVA [cerebrovascular rer day is Monday in the PM				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00705	B. WING		11/	25/2014
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER H	IEALTH CARE		ST SERVICE I MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21830	Continued From pa	ge 46	21830			
	p.m., when asked, ' times a week you ta responded, " No! " finger to answer ho a shower or a bath. more than one show shook his head indi would like three by When asked if he h more than one show shook his head yes During an interview registered nurse (R the facility for bathin resident requested physician order spe RN-B stated the ba room location unless or preference base RN-B stated when a admission, I let ther on a specific day. R about our bathing p are provided one tin bathing twice a day residents they just r would like additional will accommodate r spoke with R70 reg	r on 11/21/14, at 11:18 a.m., N)-B stated it was standard in ng one time a week unless a additional baths or we have a ecifying bathing frequency. thing schedule was based on as there was a specific request d on evening or morning. I visit with residents upon m know their shower or bath is RN-B stated I instruct residents process informing them baths me a week, with sponge . RN-B stated I inform heed to let staff know if they al baths and stated the facility requests. RN-B stated she arding his preference for and R70 will be scheduled for				
	A policy for bathing not provided.	choices was requested and				
	SUGGESTED MET	HOD OF CORRECTION:				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE D MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	Continued From page 47				
		ould in-service all employees choice in residents choices.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
	MN St. Statute 144 Residents of HC Fa	651 Subd. 20 Patients & c.Bill of Rights	21880			
	shall be encouraged their stay in a facility to understand and e patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home ombu	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, lischarge. Notice of the e of the facility or program, as and telephone numbers for the cility Complaints and the area udsman pursuant to the Older tion 307(a)(12) shall be uous place.				
	residential program 253C.01, every non facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires	inpatient facility, every a s defined in section acute care facility, and every ore than two people that mental health services shall rnal grievance procedure that, forth the process to be ime limits, including time ponse; provides for the patient the assistance of an a written response to written ovides for a timely decision by				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00705	B. WING		11/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAUFR I	HEALTH CARE		ST SERVICE I	DRIVE		
			MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	residential program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed to	ge 48 Compliance by hospitals, hs as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the rritten internal grievance	21880			
	by: Based on observati review, the facility fa complaints timely fo reviewed in the san room complaints.	ent is not met as evidenced on, interview, and document ailed to address cool room or 1 of 6 residents (R24) nple on west wing with cold				
	During interview on the room was cold. cold room to staff. (revealed R24's bed	cold room temperatures. 11/18/14, at 8:58 a.m., stated R24 stated had reported the Observations at that time was positioned by the a wheelchair and R24 was ater and blanket.				
	p.m., director of env verified the cold roc spot checked room was a complaint. H had cold temperatu	t tour on 11/20/14, at 1:30 vironmental services (DES-A) oms for R24. DES-A stated he temperatures only if there e stated last week the facility re complaints on east wing He stated he was not aware of the on west wing.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SAUER H	HEALTH CARE		ST SERVICE E ., MN 55987	DRIVE		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21880	Continued From pa	age 49	21880			
	policy dated 10/1/0 "There is adequate comfortable tempe during the heating s SUGGESTED MET administrator could for addressing resid them timely.	of facility physical environment 9-patient environment: #2. • heating system to maintain ratures of at least 71 degrees system." IHOD OF CORRECTION: The I in-service all staff responsible dent complaints to act upon R CORRECTION: Twenty-one				
	epartment of Health					