DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	/X.	XX	
Fac	ility	ID.	00705

		10 22 00::11 2			22011/21/102/101	T	-	
1. MEDICARE/MEDICAID P NO.(L1) 245102	ROVIDER	3. NAME AND AD (L3) SAUER HE A		CILITY		4. TYPE OF ACTI	ON: 7 _(L8) 2. Recertification	
2. STATE VENDOR OR MED (L2) 493543800	DICAID NO.	(L4) 1635 WEST (L5) WINONA, M		RIVE	(L6) 55987	3. Termination 5. Validation	4. CHOW6. Complaint	
5. EFFECTIVE DATE CHANG (L9)	GE OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	OF HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint	
	01/17/2017 (L34) S: (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	71 (L18) 71 (L17)	1. A	equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of S 7. Medical D 8. Patient Ro 9. Beds/Room	ervices Limit irector om Size	
		Requirements	and/or Applied V	warvers.	* Code: A	(L12)		
	9 SNF 19 SNF 71	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
	38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):				
17. SURVEYOR SIGNATURE	E	Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Gary Nederho	ff, Unit Superviso	<u>or</u> 0	1/19/2017	(L19)	Kamala Fiske-Downing, I	Enforcement Spec	ialist 4/5/2017 (L20)	
	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF EI			IPLIANCE WITH HTS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 			
1. Facility is Elig	_				3. Both of the Above :			
2. Facility is not	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION 01/19/1967	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	07-Provi	der Status Change	
(L	B. Rescind S	uspension Date:	(L44) (L45)			00-Activ	•	
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-153	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245102

April 5, 2017

Ms. Sara Blair, Administrator Sauer Health Care 1635 West Service Drive Winona, MN 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 January 10, 2017 the above facility is certified for:

Skilled Nursing Facility/Nursing Facility Beds 71

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 19, 2017

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

RE: Project Number S5102026

Dear Ms. Blair:

On December 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016 that included an investigation of complaint number. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 17, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 10, 2017 and therefore remedies outlined in our letter to you dated December 15, 2016, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

POST-CERTIFICATION REVISIT REPORT

	1 001 021111110/1110	THE TION HE ON		_	
	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	1/17/2017	Y3
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).

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix F0282 Reg. # 483.21(b)(3)(i	Correction Completed 01/10/2017	ID Prefix F031 Reg. # LSC	8 5(c)(2)(3)	Correction Completed 01/10/2017	ID Prefix Reg. # LSC	F0329 483.45(d)	Correction Completed 01/10/2017
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GPN/kfd	DATE 01/19/2017	SIGNATURE OF	SURVEYOR	10160	DATE 1/	17/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					s 🗆 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7XXX Facility ID: 00705

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MEDICARE/MEDICAID PROVID NO.(L1) 245102	DER	3. NAME AND AI (L3) SAUER HE				4. TYPE O	<u> </u>	
2. STATE VENDOR OR MEDICAID) NO	(L4) 1635 WEST	SERVICE D	RIVE		1. Initial 3. Termina	2. Recertification ation 4. CHOW	
(L2) 493543800	TNO.	(L5) WINONA, N	MN		(L6) 55987	5. Validati 7. On-Site	ion 6. Complaint	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATE	GORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Sui	rvey After Complaint	
6. DATE OF SURVEY 12/0)1/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		D FIVE DIG D INT	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEA	R 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 CERTIFICATIO	N	10.THE FACILITY	Y IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	f The Following R	equirements:	
To (b):		_	equirements		2. Technical Personne	_ 6. Sco	ope of Services Limit	
		Complianc	e Based On:		3. 24 Hour RN	7. Me	edical Director	
12.Total Facility Beds	71 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural S	NF) 8. Pat	tient Room Size	
13.Total Certified Beds	71 (L18) 71 (L17)	V D Notin Com	1'		5. Life Safety Code	9. Be	ds/Room	
13. Total Certified Beds	/1 (E1/)	X B. Not in Cor Requirements	and/or Applied	-	* Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN	1	**		15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L	15)	
71	-,				1 mar (1) (1) 11 1 mar (1) (1).	·	,	
(L37) (L38)	(L39)	(I.42)	(L43)					
(L37) (L36)	(L39)	(L42)	(LA3)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Christina Smith, H	FE NE II	1	12/20/2016	(L19)	Kamala Fiske-Downing,	Enforcement	Specialist 01/13/2017 (L20)	
PA	RT II - TO BE	COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE S	STATE AGEN	ICY	
19. DETERMINATION OF ELIGIBI	LITY		MPLIANCE WIT	TH CIVIL	21. 1. Statement of Fina			
1. Facility is Eligible to l	Participate	RIGHTS ACT:			2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)3. Both of the Above :			
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION	ī:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ATE	VOLUNTARY 0	<u>0</u> <u>I</u>	NVOLUNTARY	
01/19/1967					01-Merger, Closure	0:	5-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg	sement 00	6-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	ion	THER	
Zer Bre Errier eren Britz.		n of Admissions:			04-Other Reason for Withdrawal	_	7-Provider Status Change	
			(L44)				0-Active	
(L27)	B. Rescind St	uspension Date:	, ,					
			(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY			30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVA	L DATE				
	(L32)			(L33)	DETERMINATION APP	PROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 15, 2016

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

RE: Project Number S5102026

Dear Ms. Blair:

On December 1, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5102018 that was found to be unsubstantiated.

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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

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 10, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2017 (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 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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 12/20/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		245102	B. WING		12/0	01/2016
	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 YMUST 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	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 000			
F 282 SS=D	enrolled in ePOC, y at the bottom of the form. Your electroni be used as verificated. Upon receipt of an a con-site revisit of you validate that substate regulations has been your verification. "In addition, completed at the time." An investigation of a completed. The corder of the completed at the time. (b)(3) Comprehensions.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with laint investigation(s) were also ne of the recertification survey. complaint H5102018 was implaint was not substantiated. RVICES BY QUALIFIED ARE PLAN	F 282			1/10/17
	as outlined by the c must- (ii) Be provided by c accordance with ea care. This REQUIREMEN	omprehensive care plan,				
	failed to provide ran as care planned to	eview and interview the facility age of motion (ROM) services prevent a decline in ROM ident (R48) reviewed for services.		In response to the above stated cita Sauer Health Care has taken the for action: " R48 continues on hospice serviry R48 continues to require extensional assistance with activities of daily	llowing ces sive to	

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

TITLE

(X6) DATE

Electronically Signed

12/19/2016

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245102	B. WING		12	/01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 282	Findings include: R48's face quarter dated 11/1/16 ident total assistance wit ROM impairments extremities. R48's care plan, wir R48 had limited rar The care plan ident functional maintena contractures and paradminister Morphin Ativan (antianxiety) R48's functional marecommendations, restorative nursing passive range of mupper and lower ex will tolerate. Hold k seconds. To be do Review of the Rest for following month 08/2016 received Fropportunities, none 09/2016 received Fropportunities, none 10/2016 received Fropportun	y Minimum Data Set (MDS), ified R48 required extensive to a activities of daily living and to both upper and lower th print date 12/1/16 indicated age of motion to all extremities. ified R48 the need for ance services to prevent ain with an intervention to be (opioid analgesic) and prior to ROM. Aintenance program dated 3/1/16 indicated assistant staff to perform otion (PROM) daily to both the tremities; 2 sets of 10, or as nee extensions for up to 5 ne every day every shift 6-2. For a time Service Tracking forms is: FOM 20 out of 31 refused. FOM 10 out of 30 refused. FOM 10 out of 31 opportunities need. FOM 10 out of 31 opportunities need.	F 2	living and ROM. " R48 continues to harange of motion to all etter and a continues to maintenance services place as follows: o Functional Mainter ROM): Complete PRO upper and lower extremor as will tolerate. Hold for up to 5 seconds. State services daily with goal acceptance from resid R48 continues to have goal in place but this haread as follows: o Disease process respected decline but goal in place but this haread as follows: o Disease process respected decline but goal in related to limitation the review date. "The facility policy, Functional Maintenance was revised on 12/7/20. "The facility policy, was revised on 11/28/2. "The Registered Numanager will complete completion of all order functional maintenance." Citation and Plan or reviewed at Quality Assertion will be pappropriate staff with a receipt of training on o 10, 2017.	extremities. equire functional and has orders in nance: (Passive M exercises to both mities; 2 sets of 10, I knee extensions raff to attempt I of 3 times a week ent. have a care plan as been modified to esults in an oal will be to slow nt any increase in n in ROM through Restorative and re Programming 016. Care Plan Policy 2016. urse Program routine audits for ed restorative and e services. of Correction will be surance ment Meeting on provided to all staff confirming	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245102	B. WING	 	12/0	01/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 SS=D	stated R48 is set up with set goals to ma contracture, with PF extremities complete after lunch if not co On 12/1/16 at 11:35 (DON), stated the eto complete her the used to become stirstated that she was receiving therapy. The facility policy, FM aintenance Prograprocedure to asses program, report dec 483.25(c)(2)(3) INC DECREASE IN RAICO Mobility. (2) A resident with I receives appropriate increase range of medecrease in range of medecrease in range of medicine independent of the propriate service to maintain or impropracticable independent increase range of medecrease in range of medecrease in range of medicine independent increase range of medecrease in range of medicine independent increase range of medecrease in range of medicine independent increase range of medicine increase range of m	a.m. registered nurse (RN)-B of for functional maintenance aintain and prevent ROM lower and upper ted daily. Staff will complete impleted in the morning. Sa.m. the director of nursing expectation would be for R48 rapy as ordered adding R48 ff during therapy. The DON a unaware R48 was not restorative/Functional amming dated 6/20/2013 is quarterly, RN to manage the cline for change in program. CREASE/PREVENT INGE OF MOTION imited range of motion is treatment and services to notion and/or to prevent further of motion. imited mobility receives is, equipment, and assistance over mobility with the maximum adence unless a reduction in	F 282	Compliance for adherence to this post the responsibility of the Register Nurse Program Manager with overa compliance being the responsibility Facility Administrator and the Direct Nursing Services. In response to the above stated cit Sauer Health Care has taken the foaction: "R48 continues to require extension."	red all of the tor of	1/10/17

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245102	B. WING			12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALIEDI	IEALTH OADE			1	635 WEST SERVICE DRIVE		
SAUER	HEALTH CARE			٧	VINONA, MN 55987		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLÉTION DATE
F 318	Continued From pa	ge 3	F 3	18			
	motion as recomme	ended by physical therapy.			total assistance with activities of da	ily	
	Findings include:				living and ROM. " R48 continues to have limitation"	ns in	
	R48's face sheet id	ated 12/1/16 identified a			range of motion to all extremities. " R48 continues to require functi	onal	
		ntia and breast cancer.			maintenance services and has order		
	R48's quarterly Min	imum Data Set (MDS), dated			place as follows:		
		48 required extensive to total			o Functional Maintenance: (Pass		
		ivities of daily living ROM nupper and lower extremities.			ROM): Complete PROM exercises		
	impairments to boti	rupper and lower extremities.			upper and lower extremities; 2 sets or as will tolerate. Hold knee extens		
	R48's care plan, da	ted 12/1/16 indicated R48 had			for up to 5 seconds. Staff to attempt		
	limited range of mo	tion to all extremities. The			services daily with goal of 3 times a		
		R48 the need for functional			acceptance from resident.		
		ces to prevent contractures			" R48 continues to have a care p		
		ervention to administer nalgesic) and Ativan			goal in place but this has been moderead as follows:	illea to	
		the restorative range of			o Disease process results in an		
	motion (ROM).	ű			expected decline but goal will be to		
					this decline and prevent any increa		
		aintenance program			pain related to limitation in ROM th	rough	
		dated 3/1/2016 indicated assistant staff to perform			the review date. " R48 spouse was consulted on		
		otion (PROM) daily to both			12/19/2016 to discuss the noted co	ncerns	
		tremities; 2 sets of 10, or as			during the state visit and to review		
		nee extensions for up to 5			plan for ongoing care for R48.		
	seconds. To be do	ne every day every shift 6-2.			" The facility policy, Restorative		
	Davison of the Deat	anatina Camina Tradition forms			Functional Maintenance Programm	ing	
	for following months	orative Service Tracking forms			was revised on 12/7/2016. " The facility policy, Care Plan Policy	olicy	
	08/2016 received R				was revised on 11/28/2016.	Jiley	
	opportunities, none				" The Registered Nurse Program	ı	
	09/2016 received R				Manager will complete routine audi		
	opportunities, none				completion of all ordered restorativ		
		OM 10 out of 31 opportunities			functional maintenance services.	DC1.	
	and refused one tim	ne.			" Physical Therapist will complet		
	R48's nursing progr	ress notes reflected an entry			measurement assessment for R48 monthly for three months.	once	
		2016 at 3:19 p.m. The entry			" Citation and Plan of Correction	will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245102	B. WING		12/	01/2016
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST 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) COMPLETION DATE
F 318	functional maintena have no contracture Will continue to mo On 12/1/16 at 7:45 (NA)-C, stated the restorative aide NA exercises before ai the day. On 12/1/16 at 8:19 stated R48 is set up with set goals to ma contracture, with Plextremities comple after lunch if not co Physical Therapy Departme Discharged from Plant 12/01/2016, worsened and to colong as it is comfor Therapy Departme Discharged from Plant 11/14/14 prior to 12 therapy/follow-throunursing staff: nursing ambulate with hand chair to follow. On 12/1/16 at 11:35 (DON), stated the eto complete her the used to become stistated that she was receiving therapy. The facility policy, Maintenance Programocedure to assess	ve range of motion (PROM) ance programs goal was to es and no decline in her ROM.	F 318	reviewed at Quality Assurance Performance Improvement Meet January 18, 2017. "Education will be provided to appropriate staff with all staff con receipt of training on or before Ja 10, 2017. Compliance for adherence to this be the responsibility of the Regis Nurse Program Manager with ov compliance being the responsibil Facility Administrator and the Dira Nursing Services.	ofirming anuary s plan will tered erall ity of the	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245102	B. WING			12/0	01/2016
	PROVIDER OR SUPPLIER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 SS=D	(d) Unnecessary Drieman drug regimen must drugs. An unnecessused— (1) In excessive does therapy); or (2) For excessive descriptions of the descr	rugs-General. Each resident's be free from unnecessary sary drug is any drug when se (including duplicate drug uration; or	F3	329	In response to the above stated cita Sauer Health Care has taken the fol action: " Primary provider reviewed medications and dictated a note just use for R25. " Facility policy for the use of psychotropic medications was review but not modified at this time. " The GDR form used by the facil was modified to include specific guidelines for justification in documentation/dictation for provider	llowing tifying wed ity	1/10/17
	diagnosis that inclu	o facility on 2/6/15, with ded major depressive with severe psychotic			when stating contraindications to reductions.	S	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245102	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER		1	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	facility admission refacility identified Riset (MDS), an assecognitively intact, horeceived antipsychological antianxiety medicated behaviors and imadminister medicated behaviors, ensure and identified non-potential included readir reassurance and time. Document review of 11/30/16, revealed buspirone 7.5 mg to start date of 3/5/15 trazodone 50 mg di 3/11/15; zyprexa 5 mg at be disorder, start date. Document review of administration recorrevealed medication. Document review of administration recorrevealed medication of the pharmacist commercommendation suphysician to acceparecommendations.	iety disorder, according to ecord. 25 on quarterly Minimum Data essment dated 11/11/16, as ad moods, no behaviors, and otic, antidepressant and tions. If R25's care plan dated staff R25 received psychotropic terventions included to ions, document target behavior was not pain related, oharmacological interventions and books, family visits, me to calm down. If physician orders print dated orders included the following: wo times a day for anxiety, ally for insomnia, start date of dtime for major depressive of 2/6/15.	F 329	" Audits will be completed to e comprehensive provider justificate been provided when GDRs are oby the provider. " Citation and Plan of Correction reviewed at Quality Assurance Performance Improvement Meet January 18, 2017. " Education will be provided to appropriate staff with all staff connecipt of training on or before Jato, 2017. Compliance for adherence to this be the responsibility of the Consupharmacist and RN unit manage overall compliance being the responsibility Administrator and the Director of Nursing Services.	tion has leclined on will be ing on anuary splan will ultant rs with ponsibility	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245102	B. WING _		12	/01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1635 WEST SERVICE DRIVE 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	clinically contindividual because returned or worsen attempt within the finis time is likely to or increase distress @ Drug Regimen Frequired patient-spane GDR attempt is lincreased behavior. Review of the constrevealed the following 5/18/15-pharmacist olanzapine (zyprextyphysician response check mark for decing for continued use of dose reduction. 1/27/16-pharmacist trazodone from 50 practitioner response check mark for decing patient currently is a There was no furth use of trazodone with the continued use of trazodone with	adual dose reduction) is FRAINDICATED for this the residents target symptoms ed after the most recent GDR acility and a GDR attempt at impair this individual's function sed behavior. (Source:F428.60 Review). Please provide CMS pecific rationale describing why kely to impair function or in this individual.	F 32	29		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245102	B. WING			12/	01/2016
	PROVIDER OR SUPPLIER			1635	EET ADDRESS, CITY, STATE, ZIP CODE S WEST SERVICE DRIVE IONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	for R25: trazodone 50 mg, b mg is at minimum of mg is at minimum of the proof of th	0/2016, revealed the following puspar 7.5 mg, and zyprexa 5 effective dose. If facility follow up question get behaviors of nervousness sness or fidgeting, pain and shortness of breath. It were monitored from 1/1/16 to following episodes identified: 12/1/16 at 11:45 a.m., social solutions should be facility get behavior of self-reporting ocument review of facility report dated 6/15/16 to g for target behavior of the ses, revealed the following	F3	29			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` /	E SURVEY MPLETED
		245102	B. WING			12/	/01/2016
_	PROVIDER OR SUPPLIER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 635 WEST SERVICE DRIVE VINONA, MN 55987	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	nurse practitioner of preferred not to math has history of anxiecurrently sleeping wand staff feel R25 is effective dose of zycontinue zyprexa, to the During interview on verified R25 started nervousness exhibiting fidgeting, non-cardio of breath. SSD verof buspirone was rephysician responsed declined reduction. attempted gradual since admission to the During interview on verified R25 as admission to	lated 2/4/16, revealed R25 ake any medication changes, by and a sleep disorder, is well, anxiety is well-managed is currently at the minimum prexa and trazodone, plan to razodone and buspirone. 11/30/16, at 2:55 p.m., SSD is buspirone on 3/5/15, for ited by restlessness or ac chest pain and shortness iffied a gradual dose reduction equested on 3/2016, and is received dated 4/4/16, SSD verified facility had not dose reduction of buspirone		329			
	verified R25 was ac Zyprexa 5 mg for n restlessness or fide and shortness of bidose reduction of Z	11/30/16, at 2:55 p.m., SSD dmitted on 2/6/15, with ervousness exhibited by geting, non-cardiac chest pain reath. SSD verified a gradual dyprexa was requested 5/2015, onse received dated 7/10/15,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245102	B. WING _		12	/01/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 329	declined reduction. requested on 2/4/16 facility had not atter of Zyprexa since according interview on verified the Buspiro admission with no gattempted. Trazodo 3/11/15, with no graattempted. Zyprexa admission, with no attempted. On asking for a phyto why a GDR or Tirwhich at a minimum a titration/GDR and evidence including cause worsening ta functioning. None was included in this Document review of Medications policy or residents would reduced.	SSD verified reduction was 6, and declined. SSD verified inpted gradual dose reduction limission to facility. 12/1/16, director of nursing ne-dose is the same since gradual dose reductions ine-dose is the same since idual dose reductions reductions reductions dose is the same since gradual dose reductions. It is is the same since gradual dose reductions is the same since gradual dose reductions. It is is included previous attempt at why it failed nor was clinical how the GDR/titration would rest behaviors or impaired was provided beyond what is citation. If facility Use of Psychotropic dated 1/7/11, revealed eive gradual dose reduction intraindicated with appropriate	F 32	9			

F5102025

Printed: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

12/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245102

NAME OF PROVIDER OR SUPPLIER SAUER HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING_

1635 WEST SERVICE DRIVE WINONA MN 55987

		WINONA, MN 559	987		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	GULATORY PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000			
	A **				
	FIRE SAFETY				
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety - Size Marshal Division. At the time of this sidated 12/1/2016, Sauer Health Care was substantial compliance with the requirement participation in Medicare/Medicaid at 42 C Subpart 483.70(a), Life Safety from Fire, a 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Sa Code (LSC), Chapter 19 Existing Health C	State urvey found in ents for EFR, and the			
	Sauer Health Care is a 1-story building win partial basement. The building was constructed in 1966 and was determined to Type III(211) construction. In 1972, additional constructed to the South Wing that was determined to be of Type III(211) constructions were additional the North Wings that were determined to Type III (211) construction. Because the obuilding and the 4 additions are of the same of construction allowed for existing building facility was surveyed as one building, Type III(211).	ructed at sto be of on was stion. In sed to be of original one type ags, the			
	The building is fully fire sprinklered. The factors and spaces open to the corridor monitored for automatic fire department notification, and single station smoke alar the residents room.	etion in es that is			=
	The facility has a capacity of 71 beds and census of 54 at the time of the survey.	l had a			
ADODATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEN	TATIVE'S SIGNATURE	TITLE		(X6) DATE

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

IIILE

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.

Printed: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	ON WILDIOANL	& MEDICAID SERVI	OLO			CIVID IVO.	0330-0331	
STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
		245102		B. WING		12/01	/2016	
NAME OF B	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY S	STATE, ZIP CODE			
1					ICE DRIVE			
SAUERI	HEALTH CARE			A, MN 559				
	2					CTION	(Y5)	
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PREFIX TAG	OR LSC IDE	ENTIFYING INFORMATION)	COOLATORT	TAG	CROSS-REFERENCED TO THE APP		DATE	
	3., 233 152				DEFICIENCY)			
K 000	Continued From pa	age 1		K 000				
		t 42 CFR, Subpart 48	3 70(a) is	naugottatatio				
	MET.	or it, output to	((4) 10					
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Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted December 15, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5102026

Dear Ms. Blair:

The above facility was surveyed on November 28, 2016 through December 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5102018 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

Minnesota Department of Health

_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00705	B. WING	·····	12/0	1/2016
	PROVIDER OR SUPPLIER	1635 WES	DRESS, CITY, S ST SERVICE MN 55987	STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance.	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon				
	result in the assess	ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.				
	23016, surveyors or visited the above procorrection orders are completed, pleasure of the completed of the complete of the com	TS: 29, 30 and December 1, f this Department's staff, rovider and the following re issued. When corrections ase sign and date, make a s and mail or email to:				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/19/16 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00705	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAUER I	HEALTH CARE		T 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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 000	also completed at the survey." An investigation of the survey.	nent of Heatlh e 04 , Unit supervisor	2 000			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			1/10/17
	by: Based document refailed to provide rar as care planned to status for 1 of 1 reshospice cares and strings include: R48's face quarterly dated 11/1/16 ident total assistance with	ent is not met as evidenced eview and interview the facility age of motion (ROM) services prevent a decline in ROM ident (R48) reviewed for services. Y Minimum Data Set (MDS), ified R48 required extensive to a activities of daily living and to both upper and lower		In response to the above stated cits Sauer Health Care has taken the for action: " R48 continues on hospice serving R48 continues to require extentotal assistance with activities of daliving and ROM. " R48 continues to have limitation range of motion to all extremities. " R48 continues to require function maintenance services and has order place as follows: o Functional Maintenance: (Passi	ollowing rices sive to aily ons in onal ers in	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00705	B. WING		12/0	1/2016
		00703			12/0	1/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALIED	HEALTH CARE	1635 WES	T SERVICE	DRIVE		
SAULITI	ILALIII CANL	WINONA,	MN 55987			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
2 565	Continued From pa	ge 2	2 565			
				ROM): Complete PROM exercises	s to both	
	R48's care plan wit	th print date 12/1/16 indicated		upper and lower extremities; 2 set		
	R48's care plan, with print date 12/1/16 indicated R48 had limited range of motion to all extremities.			or as will tolerate. Hold knee exter		
		ified R48 the need for		for up to 5 seconds. Staff to attem		
		ance services to prevent		services daily with goal of 3 times		
		ain with an intervention to		acceptance from resident.	a week	
		e (opioid analgesic) and		" R48 continues to have a care	nlan	
	Ativan (antianxiety)			goal in place but this has been mo	•	
	Alivair (arillarixiety)	prior to redivi.		read as follows:	unieu io	
				o Disease process results in an		
	R48's functional ma	aintenance program		expected decline but goal will be to	a elow	
		dated 3/1/16 indicated		this decline and prevent any increa		
		assistant staff to perform		pain related to limitation in ROM th		
		otion (PROM) daily to both		the review date.	nougn	
		tremities; 2 sets of 10, or as		" The facility policy, Restorative	and	
		nee extensions for up to 5		Functional Maintenance Programm		
		ne every day every shift 6-2.		was revised on 12/7/2016.	······g	
	000011401 10 20 401	no overy day every erint e in		" The facility policy, Care Plan F	Policy	
	Review of the Rest	orative Service Tracking forms		was revised on 11/28/2016.	Olloy	
	for following months			" The Registered Nurse Prograi	m	
	08/2016 received R			Manager will complete routine auc		
	opportunities, none			completion of all ordered restorative		
	09/2016 received R			functional maintenance services.		
	opportunities, none			" Citation and Plan of Correction	n will be	
		OM 10 out of 31 opportunities		reviewed at Quality Assurance		
	and refused one tin			Performance Improvement Meetin	ig on	
				January 18, 2017.	_	
	On 12/1/16 at 7:45	a.m. nursing assistant (NA)-C,		" Education will be provided to		
		R48 is completed by the		appropriate staff with all staff confi	rming	
		no was NA-D that day), who		receipt of training on or before Jar		
		cises before NA's get the		2017.	- 1	
	residents up for the					
	·			Compliance for adherence to this	plan will	
	On 12/1/16 at 8:19	a.m. registered nurse (RN)-B		be the responsibility of the Registe	red	
		o for functional maintenance		Nurse Program Manager with over		
	with set goals to ma			compliance being the responsibility	y of the	
		ROM lower and upper		Facility Administrator and the Direct		
	extremities complet	ted daily. Staff will complete		Nursing Services.		
		mpleted in the morning.				
		ā.m. the director of nursing				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00705	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAUER	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	(DON), stated the eto complete her the used to become stil stated that she was receiving therapy. The facility policy, F Maintenance Prograprocedure to asses program, report dec SUGGESTED MET director of nursing or responsible for provaccording to the comonitor for compliant	expectation would be for R48 rapy as ordered adding R48 ff during therapy. The DON unaware R48 was not Restorative/Functional amming dated 6/20/2013 s quarterly, RN to manage the cline for change in program. THOD OF CORRECTION: The could in-service all staff viding cares/services mprehensive care plan and	2 565			
2 895	Motion Subp. 2. Range of that is directed towa through positioning implemented and motion comprehensive resident of a nursing services development of a nursing services appropriate increase range of multiple decrease in range of the subpropriate increase in range of the	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which ha limited range of motion e treatment and services to notion and to prevent further of motion.	2 895			1/10/17

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
		00705	B. WING		12/01	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			T SERVICE			
SAUER H	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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 4	2 895			
2 895	Based on documen facility failed to main exercises (ROM) as (R48) to prevent fur motion as recommendations include: R48's face sheet, diagnosis of demendations of demendatio	t review and interview the ntain range of motion sordered for 1 of 1 resident ther decrease in range of ended by physical therapy. atted 12/1/16 identified a atta and breast cancer. imum Data Set (MDS), dated 48 required extensive to total vities of daily living ROM aupper and lower extremities. ted 12/1/16 indicated R48 had tion to all extremities. The R48 the need for functional es to prevent contractures ervention to administer halgesic) and Ativan of the restorative range of a dated 3/1/2016 indicated assistant staff to perform on the program of the restorative range of the perform on the perform on the perform on the perform of the performance o	2 895	In response to the above stated cit Sauer Health Care has taken the faction: " R48 continues to require extertotal assistance with activities of diliving and ROM. " R48 continues to have limitation range of motion to all extremities. " R48 continues to require functing maintenance services and has ordiplace as follows: o Functional Maintenance: (Pass ROM): Complete PROM exercises upper and lower extremities; 2 setsor as will tolerate. Hold knee extent for up to 5 seconds. Staff to attempservices daily with goal of 3 times acceptance from resident. " R48 continues to have a care goal in place but this has been moread as follows: o Disease process results in an expected decline but goal will be to this decline and prevent any increasing related to limitation in ROM the the review date. " R48 spouse was consulted on 12/19/2016 to discuss the noted conting the state visit and to review for ongoing care for R48. " The facility policy, Restorative Functional Maintenance Programmas revised on 12/7/2016. " The facility policy, Care Plan Fwas revised on 11/28/2016. " The Registered Nurse Programmas revised on 11/28/2016. " The Registered Nurse Programmanager will complete routine and completion of all ordered restorations.	ollowing nsive to aily ons in ional ders in sive to both s of 10, nsions pt a week plan diffied to o slow ase in inrough oncerns the plan and ming Policy melits for	
	opportunities, none	refused. OM 10 out of 31 opportunities		completion of all ordered restorative functional maintenance services. " Physical Therapist will comple	e and	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00705	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAUER I	HEALTH CARE		T 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From particles of the day. Continued From particles of the day. Con 12/1/16 at 7:45 (NA)-C, stated the restorative aide NA exercises before aithe day. Con 12/1/16 at 8:19 stated R48 is set up with set goals to ma contracture, with Pleatremities compleafter lunch if not contracture, with Pleatremities compleafter lunch if	ress notes reflected an entry 2016 at 3:19 p.m. The entry ve range of motion (PROM) ance programs goal was to es and no decline in her ROM. nitor. a.m. nursing assistant ROM is completed by the -D, who completes the des get the residents up for a.m. registered nurse (RN)-B of for functional maintenance	2 895		3 once in will be on on irming nuary 10, plan will ered rall y of the	
	used to become sti stated that she was receiving therapy. The facility policy, F	ff during therapy. The DON unaware R48 was not Restorative/Functional amming dated 6/20/2013				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
			711 2012211101				
		00705	B. WING		12/0	1/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SAUER I	HEALTH CARE		T 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	Continued From pa	ge 6	2 895				
		s quarterly, RN to manage the cline for change in program.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the need to follow range of motion services according to assessed needs and monitor for compliance.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			1/10/17	
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the codiscontinued. In addition to the discontinued. In addition to the discontinued in the code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is incavailable through the content of the content	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in a nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992. For porated by reference. It is the Minitex interlibrary loan the Law Library. It is not					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00705	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALLED	HEALTH CARE	1635 WES	T SERVICE	DRIVE		
SAUENI	IEALIII CANE	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 7	21535			
21535	This MN Requirements: Based on observation review, the facility for reduction (GDR) or medication had been comprehensive phywas contraindicated residents (R25) who and antidepressant year. Findings include: R25 was admitted to diagnosis that includisorder, recurrent symptoms and anxifacility admission referred for the symptoms and anxifacility identified R2 Set (MDS), an assect cognitively intact, here received antipsychological antianxiety medicated behaviors and interest and identified non-put that included reading reassurance and time discourage of the symptoms.	ent is not met as evidenced on, interview, and document ailed to ensure a gradual dose tapering of psychoactive en attempted annually unless a rsician justification as to why it d was provided for 1 of 5 oreceived an antipsychotic medication for more then one ofacility on 2/6/15, with ded major depressive with severe psychotic rety disorder, according to record. 25 on quarterly Minimum Data ressment dated 11/11/16, as ad moods, no behaviors, and otic, antidepressant and ions. of R25's care plan dated taff R25 received psychotropic rerventions included to record, one of the property of the propert	21535	In response to the above stated of Sauer Health Care has taken the faction: " Primary provider reviewed medications and dictated a note juuse for R25. " Facility policy for the use of psychotropic medications was revibut not modified at this time. " The GDR form used by the fact modified to include specific guideli justification in documentation/dictal providers when stating contraindic reductions. " Audits will be completed to encomprehensive provider justification been provided when GDRs are deby the provider. " Citation and Plan of Correction reviewed at Quality Assurance Performance Improvement Meeting January 18, 2017. " Education will be provided to appropriate staff with all staff confireceipt of training on or before January 18, 2017. Compliance for adherence to this be the responsibility of the Consultation of the Facility Administrator and the Director of Nursing Services.	iewed cility was nes for ations to sure a on has clined on will be ag on rming quary 10, plan will tant is with onsibility	
	buspirone 7.5 mg to start date of 3/5/15;	vo times a day for anxiety,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
	00705		B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SAUER I	HEALTH CARE		T SERVICE	DRIVE		
		<u> </u>	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 8	21535			
	3/11/15;					
		rd for 11/1/16 to 11/29/16, ns administered as ordered.				
	report forms revealed pharmacist comme recommendation set physician to accept recommendations. I decline the above as GDR (gracultically CONT individual because returned or worsend attempt within the fathis time is likely to or increase distress @ Drug Regimen FRequired patient-spa GDR attempt is litincreased behavior					
	revealed the followi 5/18/15-pharmacist olanzapine (zyprexa Physician response check mark for dec	ultant pharmacist reports ng: recommendation to reduce a) from 5 mg to 2.5 mg. dated 7/10/15, revealed a line and no other justification f zyprexa without a gradual				
	1/27/16-pharmacist recommendation to reduce trazodone from 50 mg to 25 mg. Nurse practitioner response dated 2/4/16, revealed a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	check mark for decepatient currently is a There was no further use of trazodone were duction. 1/27/16-pharmacist olanzapine (zyprexapractitioner responsations of the check mark for decepatient currently is a There was no further use of zyprexa with Document review of monthly report for 1 for R25: trazodone 50 mg, being is at minimum of the companient review of the com	eline and a statement that at minimum effective dose. er justification for continued ithout a gradual dose a recommendation to reduce a) 5 mg to 2.5 mg. Nurse se dated 2/4/16, revealed a eline and a statement that at minimum effective dose. er justification for continued out a gradual dose reduction. If consultant pharmacist 10/2016, revealed the following ouspar 7.5 mg, and zyprexa 5 effective dose. If facility follow up question get behaviors of nervousness sness or fidgeting, pain and shortness of breath. The respective dose identified:	21535			
	During interview on 12/1/16 at 11:45 a.m., social services director (SSD) stated the facility					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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SAUER	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	identified a new tark sadness 6/2016. De follow up question in 11/30/16, monitorin self-reporting sadnes 6/2016-0 times 6/2016-0 times 8/2016-0 times 8/2016-0 times 10/2016-0 times 10/2016-1 time Document review on urse practitioner of preferred not to make history of anxiecurrently sleeping vand staff feel R25 is effective dose of zycontinue zyprexa, to verified R25 started nervousness exhibiting fidgeting, non-cardiof breath. SSD verof buspirone was rephysician response declined reduction. attempted gradual of since admission to During interview on verified R25 as adm 50 mg for sleep begradual dose reduction. attempted gradual of the same serious ince admission to precived dated 2/4/received dated 2/4/re	get behavior of self-reporting ocument review of facility report dated 6/15/16 to g for target behavior of ess, revealed the following ss: If facility nursing home note by lated 2/4/16, revealed R25 ke any medication changes, by and a sleep disorder, is well, anxiety is well-managed so currently at the minimum prexa and trazodone, plan to razodone and buspirone. In 1/30/16, at 2:55 p.m., SSD buspirone on 3/5/15, for sted by restlessness or ac chest pain and shortness ified a gradual dose reduction equested on 3/2016, and received dated 4/4/16, SSD verified facility had not dose reduction of buspirone	21535			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SAUER I	HEALTH CARE		T 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	
21535	Continued From pa	ge 11	21535				
	verified R25 sleeps eight hours a night, according to facility follow up question report for sleep monitoring. SSD verified facility had not attempted gradual dose reduction of trazodone for sleep.						
	verified R25 was ac Zyprexa 5 mg for no restlessness or fidg and shortness of br dose reduction of Z and physician respondeclined reduction. requested on 2/4/16	11/30/16, at 2:55 p.m., SSD dmitted on 2/6/15, with ervousness exhibited by leting, non-cardiac chest pain reath. SSD verified a gradual typrexa was requested 5/2015, onse received dated 7/10/15, SSD verified reduction was 5, and declined. SSD verified mpted gradual dose reduction dmission to facility.					
	verified the Buspiro admission with no gattempted. Trazodo 3/11/15, with no graattempted. Zyprexa	12/1/16, director of nursing ne-dose is the same since gradual dose reductions one-dose is the same since adual dose reductions and the same since gradual dose reductions					
	to why a GDR or Ti which at a minimum a titration/GDR and evidence including cause worsening ta	rsicians clinical justification as tration was contraindicated in included previous attempt at why it failed nor was clinical how the GDR/titration would reget behaviors or impaired was provided beyond what is citation.					
	Document review of facility Use of Psychotropic Medications policy dated 1/7/11, revealed residents would receive gradual dose reduction unless clinically contraindicated with appropriate						

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE COMPI		
		00705	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
SAUER	HEALTH CARE		MN 55987	DINVE		
(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
21535	documentation by a SUGGESTED MET director of nursing or responsible for mor gradual dose reductionical justification attempted based or including a prior attemporation for compliants.	the physician. THOD OF CORRECTION: The could in-service all staff nitoring medications needing a tion/titration and assuring a as to why it should not be a sound clinical information empt and failure. Also to	21535			

Minnesota Department of Health STATE FORM