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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7XXX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00705

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 4/5/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

71 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245102		1/17/2017

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 01/10/2017	ID Prefix F0318 Reg. # 483.25(c)(2)(3) LSC	Correction Completed 01/10/2017	ID Prefix F0329 Reg. # 483.45(d) LSC	Correction Completed 01/10/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7XXX

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Facility ID: 00705

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 12/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/13/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - 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;

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

Informal Dispute Resolution - 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
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING _____ B. WING _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. " In addition, complaint investigation(s) were also completed at the time of the recertification survey. " An investigation of complaint H5102018 was completed. The complaint was not substantiated.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based document review and interview the facility failed to provide range of motion (ROM) services as care planned to prevent a decline in ROM status for 1 of 1 resident (R48) reviewed for hospice cares and services.	F 282	In response to the above stated citation Sauer Health Care has taken the following action: " R48 continues on hospice services " R48 continues to require extensive to total assistance with activities of daily	1/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING _____ B. WING _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 Findings include: R48's face quarterly Minimum Data Set (MDS), dated 11/1/16 identified R48 required extensive to total assistance with activities of daily living and ROM impairments to both upper and lower extremities. R48's care plan, with print date 12/1/16 indicated R48 had limited range of motion to all extremities. The care plan identified R48 the need for functional maintenance services to prevent contractures and pain with an intervention to administer Morphine (opioid analgesic) and Ativan (antianxiety) prior to ROM. R48's functional maintenance program recommendations, dated 3/1/16 indicated restorative nursing assistant staff to perform passive range of motion (PROM) daily to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. To be done every day every shift 6-2. Review of the Restorative Service Tracking forms for following months: 08/2016 received ROM 20 out of 31 opportunities, none refused. 09/2016 received ROM 10 out of 30 opportunities, none refused. 10/2016 received ROM 10 out of 31 opportunities and refused one time On 12/1/16 at 7:45 a.m. nursing assistant (NA)-C, stated the ROM for R48 is completed by the restorative aide (who was NA-D that day), who completes the exercises before NA's get the residents up for the day.	F 282	living and ROM. " R48 continues to have limitations in range of motion to all extremities. " R48 continues to require functional maintenance services and has orders in place as follows: o Functional Maintenance: (Passive ROM): Complete PROM exercises to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. Staff to attempt services daily with goal of 3 times a week acceptance from resident. " R48 continues to have a care plan goal in place but this has been modified to read as follows: o Disease process results in an expected decline but goal will be to slow this decline and prevent any increase in pain related to limitation in ROM through the review date. " The facility policy, Restorative and Functional Maintenance Programming was revised on 12/7/2016. " The facility policy, Care Plan Policy was revised on 11/28/2016. " The Registered Nurse Program Manager will complete routine audits for completion of all ordered restorative and functional maintenance services. " Citation and Plan of Correction will be reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING _____ B. WING _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 On 12/1/16 at 8:19 a.m. registered nurse (RN)-B stated R48 is set up for functional maintenance with set goals to maintain and prevent contracture, with PROM lower and upper extremities completed daily. Staff will complete after lunch if not completed in the morning. On 12/1/16 at 11:35 a.m. the director of nursing (DON), stated the expectation would be for R48 to complete her therapy as ordered adding R48 used to become stiff during therapy. The DON stated that she was unaware R48 was not receiving therapy. The facility policy, Restorative/Functional Maintenance Programming dated 6/20/2013 procedure to assess quarterly, RN to manage the program, report decline for change in program.	F 282	Compliance for adherence to this plan will be the responsibility of the Registered Nurse Program Manager with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to maintain range of motion exercises (ROM) as ordered for 1 of 1 resident (R48) to prevent further decrease in range of	F 318	In response to the above stated citation Sauer Health Care has taken the following action: " R48 continues to require extensive to	1/10/17

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F 318	Continued From page 3 motion as recommended by physical therapy. Findings include: R48's face sheet, dated 12/1/16 identified a diagnosis of dementia and breast cancer. R48's quarterly Minimum Data Set (MDS), dated 11/1/16 identified R48 required extensive to total assistance with activities of daily living ROM impairments to both upper and lower extremities. R48's care plan, dated 12/1/16 indicated R48 had limited range of motion to all extremities. The care plan identified R48 the need for functional maintenance services to prevent contractures and pain with an intervention to administer Morphine (opioid analgesic) and Ativan (antianxiety) prior to the restorative range of motion (ROM). R48's functional maintenance program recommendations, dated 3/1/2016 indicated restorative nursing assistant staff to perform passive range of motion (PROM) daily to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. To be done every day every shift 6-2. Review of the Restorative Service Tracking forms for following months: 08/2016 received ROM 20 out of 31 opportunities, none refused. 09/2016 received ROM 10 out of 30 opportunities, none refused. 10/2016 received ROM 10 out of 31 opportunities and refused one time. R48's nursing progress notes reflected an entry recorded on 10/26/2016 at 3:19 p.m. The entry	F 318	total assistance with activities of daily living and ROM. " R48 continues to have limitations in range of motion to all extremities. " R48 continues to require functional maintenance services and has orders in place as follows: o Functional Maintenance: (Passive ROM): Complete PROM exercises to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. Staff to attempt services daily with goal of 3 times a week acceptance from resident. " R48 continues to have a care plan goal in place but this has been modified to read as follows: o Disease process results in an expected decline but goal will be to slow this decline and prevent any increase in pain related to limitation in ROM through the review date. " R48 spouse was consulted on 12/19/2016 to discuss the noted concerns during the state visit and to review the plan for ongoing care for R48. " The facility policy, Restorative and Functional Maintenance Programming was revised on 12/7/2016. " The facility policy, Care Plan Policy was revised on 11/28/2016. " The Registered Nurse Program Manager will complete routine audits for completion of all ordered restorative and functional maintenance services. " Physical Therapist will complete ROM measurement assessment for R48 once monthly for three months. " Citation and Plan of Correction will be	

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F 318	Continued From page 4 indicated the passive range of motion (PROM) functional maintenance programs goal was to have no contractures and no decline in her ROM. Will continue to monitor. On 12/1/16 at 7:45 a.m. nursing assistant (NA)-C, stated the ROM is completed by the restorative aide NA-D, who completes the exercises before aides get the residents up for the day. On 12/1/16 at 8:19 a.m. registered nurse (RN)-B stated R48 is set up for functional maintenance with set goals to maintain and prevent contracture, with PROM lower and upper extremities completed daily. Staff will complete after lunch if not completed in the morning. Physical Therapy Department Document Patient Assesses for Physical Therapy/Rehab Needs dated 12/01/2016, read; resident contractures worsened and to continue with range of motion as long as it is comfortable. Most recent Physical Therapy Department Document Patient Discharged from Physical Therapy last treatment 11/14/14 prior to 12/1/16 read; physical therapy/follow-through orders for rehab and nursing staff: nursing o transfer with assist of two, ambulate with handheld assist of two with wheel chair to follow. On 12/1/16 at 11:35 a.m. the director of nursing (DON), stated the expectation would be for R48 to complete her therapy as ordered adding R48 used to become stiff during therapy. The DON stated that she was unaware R48 was not receiving therapy. The facility policy, Restorative/Functional Maintenance Programming dated 6/20/2013 procedure to assess quarterly, RN to manage the program, report decline for change in program.	F 318	reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017. Compliance for adherence to this plan will be the responsibility of the Registered Nurse Program Manager with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	

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F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a gradual dose reduction (GDR) or tapering of psychoactive medication had been attempted annually unless a comprehensive physician justification as to why it was contraindicated was provided for 1 of 5 residents (R25) who received an antipsychotic and antidepressant medication for more then one year. Findings include: R25 was admitted to facility on 2/6/15, with diagnosis that included major depressive disorder, recurrent with severe psychotic	F 329	In response to the above stated citation Sauer Health Care has taken the following action: " Primary provider reviewed medications and dictated a note justifying use for R25. " Facility policy for the use of psychotropic medications was reviewed but not modified at this time. " The GDR form used by the facility was modified to include specific guidelines for justification in documentation/dictation for providers when stating contraindications to reductions.	1/10/17

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F 329	Continued From page 6 symptoms and anxiety disorder, according to facility admission record. Facility identified R25 on quarterly Minimum Data Set (MDS), an assessment dated 11/11/16, as cognitively intact, had moods, no behaviors, and received antipsychotic, antidepressant and antianxiety medications. Document review of R25's care plan dated 11/11/16, directed staff R25 received psychotropic medications and interventions included to administer medications, document target behaviors, ensure behavior was not pain related, and identified non-pharmacological interventions that included reading books, family visits, reassurance and time to calm down. Document review of physician orders print dated 11/30/16, revealed orders included the following: buspirone 7.5 mg two times a day for anxiety, start date of 3/5/15; trazodone 50 mg daily for insomnia, start date of 3/11/15; zyprexa 5 mg at bedtime for major depressive disorder, start date of 2/6/15. Document review of R25's medication administration record for 11/1/16 to 11/29/16, revealed medications administered as ordered. Document review of facility consultant pharmacist report forms revealed the form included a pharmacist comment section, a pharmacist recommendation section, and a section for the physician to accept or decline pharmacist recommendations. The decline statement read as follows: I decline the re recommendation(s)	F 329	" Audits will be completed to ensure a comprehensive provider justification has been provided when GDRs are declined by the provider. " Citation and Plan of Correction will be reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017. Compliance for adherence to this plan will be the responsibility of the Consultant Pharmacist and RN unit managers with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	

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F 329	Continued From page 7	F 329		

above as GDR (gradual dose reduction) is CLINICALLY CONTRAINDICATED for this individual because the residents target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior. (Source:F428.60 @ Drug Regimen Review). Please provide CMS Required patient-specific rationale describing why a GDR attempt is likely to impair function or increased behavior in this individual.

Review of the consultant pharmacist reports revealed the following:
5/18/15-pharmacist recommendation to reduce olanzapine (zyprexa) from 5 mg to 2.5 mg. Physician response dated 7/10/15, revealed a check mark for decline and no other justification for continued use of zyprexa without a gradual dose reduction.

1/27/16-pharmacist recommendation to reduce trazodone from 50 mg to 25 mg. Nurse practitioner response dated 2/4/16, revealed a check mark for decline and a statement that patient currently is at minimum effective dose. There was no further justification for continued use of trazodone without a gradual dose reduction.

1/27/16-pharmacist recommendation to reduce olanzapine (zyprexa) 5 mg to 2.5 mg. Nurse practitioner response dated 2/4/16, revealed a check mark for decline and a statement that patient currently is at minimum effective dose. There was no further justification for continued use of zyprexa without a gradual dose reduction.

Document review of consultant pharmacist

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F 329	Continued From page 8 monthly report for 10/2016, revealed the following for R25: trazodone 50 mg, buspar 7.5 mg, and zyprexa 5 mg is at minimum effective dose. Document review of facility follow up question report, revealed target behaviors of nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. The target behaviors were monitored from 1/1/16 to 11/30/16, with the following episodes identified: 1/2016-2 times 2/2016-4 times 3/2016-0 times 4/2016-2 times 5/2016-0 times 6/2016-0 times 7/2016-1 time 8/2016-1 time 9/2016-2 times 10/2016-2 times 11/2016-0 times During interview on 12/1/16 at 11:45 a.m., social services director (SSD) stated the facility identified a new target behavior of self-reporting sadness 6/2016. Document review of facility follow up question report dated 6/15/16 to 11/30/16, monitoring for target behavior of self-reporting sadness, revealed the following episodes of sadness: 6/2016-0 times 7/2016-0 times 8/2016-0 times 8/2016-0 times 10/2016-0 times 11/2016-1 time Document review of facility nursing home note by	F 329		

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nurse practitioner dated 2/4/16, revealed R25 preferred not to make any medication changes, has history of anxiety and a sleep disorder, is currently sleeping well, anxiety is well-managed and staff feel R25 is currently at the minimum effective dose of zyprexa and trazodone, plan to continue zyprexa, trazodone and buspirone.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 started buspirone on 3/5/15, for nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. SSD verified a gradual dose reduction of buspirone was requested on 3/2016, and physician response received dated 4/4/16, declined reduction. SSD verified facility had not attempted gradual dose reduction of buspirone since admission to facility.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 as admitted 2/6/15, and trazodone 50 mg for sleep began 3/2015. SSD verified a gradual dose reduction of trazodone was requested 1/2016, and physician response received dated 2/4/16, declined reduction due to R25 was at the minimum effective dose. SSD 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.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 was admitted on 2/6/15, with Zyprexa 5 mg for nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. SSD verified a gradual dose reduction of Zyprexa was requested 5/2015, and physician response received dated 7/10/15,

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F 329	Continued From page 10	F 329		

declined reduction. SSD verified reduction was requested on 2/4/16, and declined. SSD verified facility had not attempted gradual dose reduction of Zyprexa since admission to facility.

During interview on 12/1/16, director of nursing verified the Buspirone-dose is the same since admission with no gradual dose reductions attempted. Trazodone-dose is the same since 3/11/15, with no gradual dose reductions attempted. Zyprexa-dose is the same since admission, with no gradual dose reductions attempted.

On asking for a physicians clinical justification as to why a GDR or Titration was contraindicated which at a minimum included previous attempt at a titration/GDR and why it failed nor was clinical evidence including how the GDR/titration would cause worsening target behaviors or impaired functioning. None was provided beyond what was included in this 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 documentation by the physician.

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	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 12/1/2016, Sauer Health Care was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Sauer Health Care is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type III(211) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type III(211)construction. In 1976, 1982, and 1995 additions were added to the North Wings that were determined to be of Type III (211) construction. Because the original building and the 4 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III(211). The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification, and single station smoke alarms in the residents room. The facility has a capacity of 71 beds and had a census of 54 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota Department of Health

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 only a suggestion 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: _____ B. WING _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 28, 29, 30 and December 1, 23016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to:	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/19/16

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2 000	Continued From page 1 Minnesota Department of Heatlh 18 Wood Lake Drive Rochester, MN 55904 c/o Gary Nederhoff, Unit supervisor gary.nederhoff@state.mn.us "In addition, complaint investigation(s) were also completed at the time of the licensing survey." An investigation of complaint/s H5102018 was completed. The complaint was not substantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based document review and interview the facility failed to provide range of motion (ROM) services as care planned to prevent a decline in ROM status for 1 of 1 resident (R48) reviewed for hospice cares and services. Findings include: R48's face quarterly Minimum Data Set (MDS), dated 11/1/16 identified R48 required extensive to total assistance with activities of daily living and ROM impairments to both upper and lower extremities.	2 565	In response to the above stated citation Sauer Health Care has taken the following action: " R48 continues on hospice services " R48 continues to require extensive to total assistance with activities of daily living and ROM. " R48 continues to have limitations in range of motion to all extremities. " R48 continues to require functional maintenance services and has orders in place as follows: o Functional Maintenance: (Passive	1/10/17

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2 565	Continued From page 2 R48's care plan, with print date 12/1/16 indicated R48 had limited range of motion to all extremities. The care plan identified R48 the need for functional maintenance services to prevent contractures and pain with an intervention to administer Morphine (opioid analgesic) and Ativan (antianxiety) prior to ROM. R48's functional maintenance program recommendations, dated 3/1/16 indicated restorative nursing assistant staff to perform passive range of motion (PROM) daily to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. To be done every day every shift 6-2. Review of the Restorative Service Tracking forms for following months: 08/2016 received ROM 20 out of 31 opportunities, none refused. 09/2016 received ROM 10 out of 30 opportunities, none refused. 10/2016 received ROM 10 out of 31 opportunities and refused one time On 12/1/16 at 7:45 a.m. nursing assistant (NA)-C, stated the ROM for R48 is completed by the restorative aide (who was NA-D that day), who completes the exercises before NA's get the residents up for the day. On 12/1/16 at 8:19 a.m. registered nurse (RN)-B stated R48 is set up for functional maintenance with set goals to maintain and prevent contracture, with PROM lower and upper extremities completed daily. Staff will complete after lunch if not completed in the morning. On 12/1/16 at 11:35 a.m. the director of nursing	2 565	ROM): Complete PROM exercises to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. Staff to attempt services daily with goal of 3 times a week acceptance from resident. " R48 continues to have a care plan goal in place but this has been modified to read as follows: o Disease process results in an expected decline but goal will be to slow this decline and prevent any increase in pain related to limitation in ROM through the review date. " The facility policy, Restorative and Functional Maintenance Programming was revised on 12/7/2016. " The facility policy, Care Plan Policy was revised on 11/28/2016. " The Registered Nurse Program Manager will complete routine audits for completion of all ordered restorative and functional maintenance services. " Citation and Plan of Correction will be reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017. Compliance for adherence to this plan will be the responsibility of the Registered Nurse Program Manager with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	

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2 565	Continued From page 3 (DON), stated the expectation would be for R48 to complete her therapy as ordered adding R48 used to become stiff during therapy. The DON stated that she was unaware R48 was not receiving therapy. The facility policy, Restorative/Functional Maintenance Programming dated 6/20/2013 procedure to assess quarterly, RN to manage the program, report decline for change in program. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for providing cares/services according to the comprehensive care plan and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		1/10/17

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2 895	Continued From page 4 Based on document review and interview the facility failed to maintain range of motion exercises (ROM) as ordered for 1 of 1 resident (R48) to prevent further decrease in range of motion as recommended by physical therapy. Findings include: R48's face sheet, dated 12/1/16 identified a diagnosis of dementia and breast cancer. R48's quarterly Minimum Data Set (MDS), dated 11/1/16 identified R48 required extensive to total assistance with activities of daily living ROM impairments to both upper and lower extremities. R48's care plan, dated 12/1/16 indicated R48 had limited range of motion to all extremities. The care plan identified R48 the need for functional maintenance services to prevent contractures and pain with an intervention to administer Morphine (opioid analgesic) and Ativan (antianxiety) prior to the restorative range of motion (ROM). R48's functional maintenance program recommendations, dated 3/1/2016 indicated restorative nursing assistant staff to perform passive range of motion (PROM) daily to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. To be done every day every shift 6-2. Review of the Restorative Service Tracking forms for following months: 08/2016 received ROM 20 out of 31 opportunities, none refused. 09/2016 received ROM 10 out of 30 opportunities, none refused. 10/2016 received ROM 10 out of 31 opportunities and refused one time.	2 895	In response to the above stated citation Sauer Health Care has taken the following action: " R48 continues to require extensive to total assistance with activities of daily living and ROM. " R48 continues to have limitations in range of motion to all extremities. " R48 continues to require functional maintenance services and has orders in place as follows: o Functional Maintenance: (Passive ROM): Complete PROM exercises to both upper and lower extremities; 2 sets of 10, or as will tolerate. Hold knee extensions for up to 5 seconds. Staff to attempt services daily with goal of 3 times a week acceptance from resident. " R48 continues to have a care plan goal in place but this has been modified to read as follows: o Disease process results in an expected decline but goal will be to slow this decline and prevent any increase in pain related to limitation in ROM through the review date. " R48 spouse was consulted on 12/19/2016 to discuss the noted concerns during the state visit and to review the plan for ongoing care for R48. " The facility policy, Restorative and Functional Maintenance Programming was revised on 12/7/2016. " The facility policy, Care Plan Policy was revised on 11/28/2016. " The Registered Nurse Program Manager will complete routine audits for completion of all ordered restorative and functional maintenance services. " Physical Therapist will complete ROM	

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2 895	Continued From page 5 R48's nursing progress notes reflected an entry recorded on 10/26/2016 at 3:19 p.m. The entry indicated the passive range of motion (PROM) functional maintenance programs goal was to have no contractures and no decline in her ROM. Will continue to monitor. On 12/1/16 at 7:45 a.m. nursing assistant (NA)-C, stated the ROM is completed by the restorative aide NA-D, who completes the exercises before aides get the residents up for the day. On 12/1/16 at 8:19 a.m. registered nurse (RN)-B stated R48 is set up for functional maintenance with set goals to maintain and prevent contracture, with PROM lower and upper extremities completed daily. Staff will complete after lunch if not completed in the morning. Physical Therapy Department Document Patient Assesses for Physical Therapy/Rehab Needs dated 12/01/2016, read; resident contractures worsened and to continue with range of motion as long as it is comfortable. Most recent Physical Therapy Department Document Patient Discharged from Physical Therapy last treatment 11/14/14 prior to 12/1/16 read; physical therapy/follow-through orders for rehab and nursing staff: nursing o transfer with assist of two, ambulate with handheld assist of two with wheel chair to follow. On 12/1/16 at 11:35 a.m. the director of nursing (DON), stated the expectation would be for R48 to complete her therapy as ordered adding R48 used to become stiff during therapy. The DON stated that she was unaware R48 was not receiving therapy. The facility policy, Restorative/Functional Maintenance Programming dated 6/20/2013	2 895	measurement assessment for R48 once monthly for three months. " Citation and Plan of Correction will be reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017. Compliance for adherence to this plan will be the responsibility of the Registered Nurse Program Manager with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	

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2 895	Continued From page 6 procedure to assess quarterly, RN to manage the program, report decline 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.	2 895		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.	21535		1/10/17

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21535	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a gradual dose reduction (GDR) or tapering of psychoactive medication had been attempted annually unless a comprehensive physician justification as to why it was contraindicated was provided for 1 of 5 residents (R25) who received an antipsychotic and antidepressant medication for more then one year. Findings include: R25 was admitted to facility on 2/6/15, with diagnosis that included major depressive disorder, recurrent with severe psychotic symptoms and anxiety disorder, according to facility admission record. Facility identified R25 on quarterly Minimum Data Set (MDS), an assessment dated 11/11/16, as cognitively intact, had moods, no behaviors, and received antipsychotic, antidepressant and antianxiety medications. Document review of R25's care plan dated 11/11/16, directed staff R25 received psychotropic medications and interventions included to administer medications, document target behaviors, ensure behavior was not pain related, and identified non-pharmacological interventions that included reading books, family visits, reassurance and time to calm down. Document review of physician orders print dated 11/30/16, revealed orders included the following: buspirone 7.5 mg two times a day for anxiety, start date of 3/5/15;	21535	In response to the above stated citation Sauer Health Care has taken the following action: " Primary provider reviewed medications and dictated a note justifying use for R25. " Facility policy for the use of psychotropic medications was reviewed but not modified at this time. " The GDR form used by the facility was modified to include specific guidelines for justification in documentation/dictation for providers when stating contraindications to reductions. " Audits will be completed to ensure a comprehensive provider justification has been provided when GDRs are declined by the provider. " Citation and Plan of Correction will be reviewed at Quality Assurance Performance Improvement Meeting on January 18, 2017. " Education will be provided to appropriate staff with all staff confirming receipt of training on or before January 10, 2017. Compliance for adherence to this plan will be the responsibility of the Consultant Pharmacist and RN unit managers with overall compliance being the responsibility of the Facility Administrator and the Director of Nursing Services.	

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trazodone 50 mg daily for insomnia, start date of 3/11/15;
zyprexa 5 mg at bedtime for major depressive disorder, start date of 2/6/15.

Document review of R25's medication administration record for 11/1/16 to 11/29/16, revealed medications administered as ordered.

Document review of facility consultant pharmacist report forms revealed the form included a pharmacist comment section, a pharmacist recommendation section, and a section for the physician to accept or decline pharmacist recommendations. The decline statement read as follows: I decline the re recommendation(s) above as GDR (gradual dose reduction) is CLINICALLY CONTRAINDICATED for this individual because the residents target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior. (Source:F428.60 @ Drug Regimen Review). Please provide CMS Required patient-specific rationale describing why a GDR attempt is likely to impair function or increased behavior in this individual.

Review of the consultant pharmacist reports revealed the following:
5/18/15-pharmacist recommendation to reduce olanzapine (zyprexa) from 5 mg to 2.5 mg. Physician response dated 7/10/15, revealed a check mark for decline and no other justification for continued use of zyprexa without a gradual dose reduction.

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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check mark for decline and a statement that patient currently is at minimum effective dose. There was no further justification for continued use of trazodone without a gradual dose reduction.

1/27/16-pharmacist recommendation to reduce olanzapine (zyprexa) 5 mg to 2.5 mg. Nurse practitioner response dated 2/4/16, revealed a check mark for decline and a statement that patient currently is at minimum effective dose. There was no further justification for continued use of zyprexa without a gradual dose reduction.

Document review of consultant pharmacist monthly report for 10/2016, revealed the following for R25:
trazodone 50 mg, buspar 7.5 mg, and zyprexa 5 mg is at minimum effective dose.

Document review of facility follow up question report, revealed target behaviors of nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. The target behaviors were monitored from 1/1/16 to 11/30/16, with the following episodes identified:
1/2016-2 times
2/2016-4 times
3/2016-0 times
4/2016-2 times
5/2016-0 times
6/2016-0 times
7/2016-1 time
8/2016-1 time
9/2016-2 times
10/2016-2 times
11/2016-0 times

During interview on 12/1/16 at 11:45 a.m., social services director (SSD) stated the facility

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identified a new target behavior of self-reporting sadness 6/2016. Document review of facility follow up question report dated 6/15/16 to 11/30/16, monitoring for target behavior of self-reporting sadness, revealed the following episodes of sadness:
6/2016-0 times
7/2016-0 times
8/2016-0 times
8/2016-0 times
10/2016-0 times
11/2016-1 time

Document review of facility nursing home note by nurse practitioner dated 2/4/16, revealed R25 preferred not to make any medication changes, has history of anxiety and a sleep disorder, is currently sleeping well, anxiety is well-managed and staff feel R25 is currently at the minimum effective dose of zyprexa and trazodone, plan to continue zyprexa, trazodone and buspirone.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 started buspirone on 3/5/15, for nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. SSD verified a gradual dose reduction of buspirone was requested on 3/2016, and physician response received dated 4/4/16, declined reduction. SSD verified facility had not attempted gradual dose reduction of buspirone since admission to facility.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 as admitted 2/6/15, and trazodone 50 mg for sleep began 3/2015. SSD verified a gradual dose reduction of trazodone was requested 1/2016, and physician response received dated 2/4/16, declined reduction due to R25 was at the minimum effective dose. SSD

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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.

During interview on 11/30/16, at 2:55 p.m., SSD verified R25 was admitted on 2/6/15, with Zyprexa 5 mg for nervousness exhibited by restlessness or fidgeting, non-cardiac chest pain and shortness of breath. SSD verified a gradual dose reduction of Zyprexa was requested 5/2015, and physician response received dated 7/10/15, declined reduction. SSD verified reduction was requested on 2/4/16, and declined. SSD verified facility had not attempted gradual dose reduction of Zyprexa since admission to facility.

During interview on 12/1/16, director of nursing verified the Buspirone-dose is the same since admission with no gradual dose reductions attempted. Trazodone-dose is the same since 3/11/15, with no gradual dose reductions attempted. Zyprexa-dose is the same since admission, with no gradual dose reductions attempted.

On asking for a physicians clinical justification as to why a GDR or Titration was contraindicated which at a minimum included previous attempt at a titration/GDR and why it failed nor was clinical evidence including how the GDR/titration would cause worsening target behaviors or impaired functioning. None was provided beyond what was included in this 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: _____ B. WING _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 12 documentation by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for monitoring medications needing a gradual dose reduction/titration and assuring a clinical justification as to why it should not be attempted based on sound clinical information including a prior attempt and failure. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		