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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OANL

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

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 **04/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 05/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/21/2014
(L33)

DETERMINATION APPROVAL

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

CCN-24-5102

On April 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 17, 2014. It was determined, based on the visit, that the facility has corrected the deficiencies issued pursuant to the
extended survey, completed on March 17, 2014, as of April 26, 2014.
As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 26, 2014. The facility is still prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two year from March 17, 2014. The Civil Money Penalty of $5,000.00 per day for the one (1) day beginning March 13, 2014 and
continuing through March 13, 2014 for a total of $5,000.0 (42 CFR 488.430 through 488.444), will remain imposed. Civil Money Penalty of $200.00 per day beginning March 14, 2014 (42 CFR 488.430 through 488.444), will remain imposed.
Mandatory denial of payment for new Medicare and Medicaid admissions effective June 17, 2014 is rescinded as of April 26, 2014. (42 CFR 488.417 (b)).

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 9, 2014

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

RE: Project Number S5102023

Dear Ms. Blair:

On April 7, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 12, 2014. (42 CFR 488.422)

On April 18, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

Civil Money Penalty of $5,000.00 per day for the one (1) day beginning March 13, 2014 and continuing through March 13, 2014 for a total of $5,000.0 (42 CFR 488.430 through 488.444)

Civil Money Penalty of $200.00 per day beginning March 14, 2014 (42 CFR 488.430 through 488.444)

Mandatory denial of payment for new Medicare and Medicaid admissions effective June 17, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on March 17, 2014 that included an investigation of complaint number H5102014. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On April 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on March 17, 2014, as of April 26, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 26, 2014.

However, as we notified you in our letter of April 7, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 18, 2014:

> Civil Money Penalty of $5,000.00 per day for the one (1) day beginning March 13, 2014 and continuing through March 13, 2014 for a total of $5,000.0 (42 CFR 488.430 through 488.444), will remain imposed.
>
> Civil Money Penalty of $200.00 per day beginning March 14, 2014 (42 CFR 488.430 through 488.444), will remain imposed.
>
> Mandatory denial of payment for new Medicare and Medicaid admissions effective June 17, 2014 is rescinded as of April 26, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245102	A. Building B. Wing	4/30/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	04/26/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	04/26/2014	ID Prefix F0272 Reg. # 483.20(b)(1) LSC	04/26/2014
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	04/26/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	04/26/2014	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	04/26/2014
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	04/26/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	04/26/2014	ID Prefix F0325 Reg. # 483.25(i) LSC	04/26/2014
ID Prefix F0329 Reg. # 483.25(l) LSC	04/26/2014	ID Prefix F0412 Reg. # 483.55(b) LSC	04/26/2014	ID Prefix F0428 Reg. # 483.60(c) LSC	04/26/2014
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	04/26/2014	ID Prefix F0441 Reg. # 483.65 LSC	04/26/2014	ID Prefix F0497 Reg. # 483.75(e)(8) LSC	04/26/2014

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/kfd	05/09/2014	15425	4/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
3/17/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245102	A. Building B. Wing 01 - MAIN BUILDING 01	4/24/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	03/25/2014	ID Prefix Reg. # NFPA 101 LSC K0018	03/19/2014	ID Prefix Reg. # NFPA 101 LSC K0029	04/03/2014
ID Prefix Reg. # NFPA 101 LSC K0154	03/31/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/09/2014	12424	04/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/11/2014	

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: OANL
Facility ID: 00705

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 04/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2014 (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

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

24-5102

On March 17, 2014, a NOTC extended survey was completed at this facility. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The most serious deficiencies were issued at a S/S level of J.

In addition, at the time of the March 17, 2014 extended survey the Minnesota Department of Health completed an investigation of complaint number H5102014, that was found to be unsubstantiated.

As a result of the survey findings. We have imposed State monitoring, effective April 12, 2014.. In addition, we have recommended to the CMS RO the following remedy for imposition and CMS has concurred.
Per instance civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Due to the extended survey and finding of substandard quality of care, the facility is subject to a loss of NATCEP for two years from March 17, 2014.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
April 7, 2014

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

RE: Project Number S5102023, H5102014

Dear Ms. Blair:

On March 17, 2014, an extended survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the March 17, 2014 extended survey the Minnesota Department of Health completed an investigation of complaint number H5102014.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the March 17, 2014 standard extended survey the Minnesota Department of Health completed an investigation of complaint number H5102014 that was found to be unsubstantiated.

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

> **<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §**

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 14, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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, Supervisor
Rochester Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: gary.nederhoff@state.mn.us

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

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- **State Monitoring effective April 12, 2014. (42 CFR 488.422)**

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- **Per instance civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)**

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Sauer Health Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 17, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 June 17, 2014 (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 September 17, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5102s14epoc.rtf

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 ______	03/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on March 10, 11, 12, 13, 14, and 17, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to provide necessary care and services to ensure safety of 1 of 5 residents (R40) in the sample reviewed for accidents, which resulted in the high potential for harm or death. Facility staff had been notified of the IJ on March 13, 2014, at 12:45 p.m. for the IJ that began on November 25, 2013. The IJ was removed on March 14, 2014, at 11:00 a.m., however non-compliance remained at the lower s/s of a D. At the time of the survey, a complaint investigation(s) was also completed. An investigation of complaint #H5102014 was completed. The complaint was not substantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		4/26/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/17/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1	F 225		

been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to immediately report allegations of

Coaching and education to staff persons involved with not reporting and

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F 225	Continued From page 2 abuse and neglect to the administrator, designated state agency and/or thoroughly investigate allegation of abuse for 2 of 3 residents (R114, R40) reviewed for allegations of abuse and neglect. Findings include: R114 had an allegation of abuse and neglect which were not immediately reported to the administrator and designated state agency. R114 was admitted to the facility on 3/22/12, with diagnosis that included vascular dementia with delusions, osteoporosis, and pathologic fracture of vertebrae, according to care plan dated 4/11/12. R114 was discharged from the facility on 7/20/13, according to the facility discharge Minimum Data Set assessment. The facility identified R114 on the quarterly Minimum Data Set, an assessment dated 6/26/13, to have had one fall with injury since last assessment. Review of the facility Safety risk evaluation dated 10/5/12, identified R114 had history of multiple falls, diagnosis of dementia, and had chair alarms and pad; and review of evaluation dated 6/26/13, identified resident had recently had falls, used grab bars and bed sensor alarm. During interview on 3/14/14, at 4:00 p.m., registered nurse-A (RN-A) stated the facility had no other fall risk assessments for R114. Document review of resident care plan dated 4/11/12, revealed R114 was at high risk for falls related to history of multiple falls, with interventions that included room by nurses station, use toilet before and after meals, bed	F 225	investigating alleged abuse, LSW, RN Manager and LPN. Informal education of information communicated to all staff via electronic charting system communication board on 3/19/14-4/2/14, memo posted for all staff viewing 3/19/14. Formal education to all staff at in-service on 4/3 occurred on the Vulnerable Adult policy, including reporting procedures, investigating and reporting to the Administrator immediately. Annual training of all employees will continue. Administrator is notified of all incident reports immediately. Will review VA policies at resident council and process for reporting at May meeting. LSW will review process for reporting and VA policy at care conferences for 3 months beginning 3/27/14. Process will be reviewed at QA meeting on 5/20/14. LSW or designee reviews every incident report daily to monitor for VA reporting compliance for three months. If not compliant, Administrator will be notified and further auditing and education of staff will occur.	

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F 225	Continued From page 3	F 225		

lowest position, tab alarm on, wear socks not nylons, and when restless meet all needs.

Document review of facility Vulnerable Adult Reporting Form dated 7/21/13, revealed the following:
On 7/20/13, at 2:20 p.m., R114 was observed in a squatting position between the foot of the bed and a chair. After returned to bed, R114 voiced pain in right hip. R114 was transferred to hospital for evaluation and determined to have a right femur fracture. R114 had a wheelchair pull tab alarm which did not sound. It was determined that the alarm was attached to resident but the cord was wrapped under the gauge of the portable oxygen tank and did not sound.
Document review of the same report revealed the administrator was notified of the incident the next day by email on 7/21/13, at 11:55 a.m.; and designated state agency notified 7/21/13, at 12:00 p. m.

During interview on 3/14/14, at 2:20 p.m., director of nursing stated she expected staff to notify her and the administrator immediately of allegations of abuse and neglect. Director of nursing stated email messages go directly to their telephone and they receive the message right away.

During interview on 3/14/14, at 5:00 p.m., The administrator verified she and the designated state agency were not notified of the 7/20/13, incident until 7/21/13. She stated she did not know why she and the designated state agency were not immediately notified of the allegation of abuse and neglect.
R40's family (F)-A reported to the facility R40 had a bruise and it may have been caused by a staff person. However, the facility did not report this

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 225	Continued From page 4	F 225		

alleged allegation to the administrator or to the designated state agency (Office of Health Facility Compliance, OHFC) nor did they do a thorough investigation of the alleged abuse.

During review of the medical record on 3/14/14 the nursing progress note revealed that on 2/20/14 at 12:58 p.m. F-A accused a staff member of causing bruising to R40's right axillary area. The progress note indicated it was very evident that the bruise was due to R40's constant leaning in the wheelchair and pushing the area against the armrest. The nurse documented, it would be impossible to prevent bruising to this area due to the manner in which the resident sits in the chair. The wheelchair arm rests are padded, however the resident continues to ram her side into the arm rests and leans over the side of the chair causing pressure and bruising. The nurse explained this to the family and they accepted the explanation. However, the nurse did not follow the abuse neglect policy and report the allegation immediately to the administrator and to the designated state agency.

On 3/14/14 at 9:25 a.m. the director of nursing (DON) indicated after the resident had a fall on 2/5/14 we were monitoring her bruising on the right axillary area which was a substantial area covered. When the family reported the bruising on 2/20/14 and accused a staff member of causing bruises to the right axillary area the DON did not investigate the allegation further. No staff members were interviewed. She agreed she should have done that. She was unsure if the administrator was notified.

On 3/14/14 at 10:00 a.m. registered nurse (RN)-C produced a document which she verified had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 been created on 3/14/14. The document indicated RN-C spoke to two different staff members who indicated the bruise was inflicted by R40's constant leaning to the right in her chair. No further investigation was conducted and the DON, administrator were not notified and neither was the state agency. On 3/14/14 at 10:05 a.m. the DON indicated neither she nor the administrator was notified of the incident and they should have been. On 3/14/14 at 10:39 a.m. social worker (SW)-A was interviewed. She was aware of the allegation on 2/20/14 and spoke to the nurse manager. We concluded the bruise was from the resident leaning to the right side. No interviews of any staff members were conducted. She agreed they failed to thoroughly investigate the bruises reported by the family member as having been inflicted by the staff. The state agency was not notified. Document review of facility Vulnerable Adult Policy dated 7/14/09, and revised dated 10/31/13, read, "A. Sauer Health Care will report ALL cases of known or suspected maltreatment of vulnerable adults to the MN Department of Health-Office of Health Facilities Complaint and appropriate Common Entry Point (CEP). All VA [vulnerable adult] reports need to be reported immediately to MDH-office of health facility complaints and CEP (Common Entry Point at county)." and "D. All VA reports must be reported to the administrator immediately. Notification of the Administrator should be done through an email."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		4/26/14

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 ______	03/17/2014

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

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F 226	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their facility policy to immediately report allegations of abuse and neglect to the administrator and designated state agency and to thoroughly investigate alleged allegations of abuse/neglect for 2 of 3 residents (R114, R40) reviewed for allegations of abuse and neglect. Findings include: Document review of facility Vulnerable Adult Policy dated 7/14/09, and revised dated 10/31/13, read, "A. Sauer Health Care will report ALL cases of known or suspected maltreatment of vulnerable adults to the MN Department of Health-Office of Health Facilities Complaint and appropriate Common Entry Point (CEP). All VA [vulnerable adult] reports need to be reported immediately to MDH-office of health facility complaints and CEP (Common Entry Point at county)." and "D. All VA reports must be reported to the administrator immediately. Notification of the Administrator should be done through an email." R114 The facility failed to follow their written policy and procedure to prohibit mistreatment and to immediately notify the administrator, state agency, and thoroughly investigate the incident of	F 226	Coaching and education to staff persons involved with not reporting and investigating alleged abuse, LSW, RN Manager and LPN. Informal education of information communicated to all staff via electronic charting system communication board on 3/19/14-4/2/14, memo posted for all staff viewing 3/19/14. Formal education to all staff at in-service on 4/3 occurred on the Vulnerable Adult policy, including reporting procedures, investigating and reporting to the Administrator immediately. Annual training of all employees will continue. Administrator is notified of all incident reports immediately. Will review VA policies at resident council and process for reporting. LSW will review process for reporting and VA policy at care conferences for 3 months beginning 3/27/14. Process will be reviewed at QA meeting on 5/20/14. LSW or designee reviews every incident report daily to monitor for VA reporting compliance for three months. If not compliant, Administrator will be notified and further auditing and education of staff will occur.	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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F 226	Continued From page 7 possible mistreatment. R114 was admitted to the facility on 3/22/12, with diagnosis that included vascular dementia with delusions, osteoporosis, and pathologic fracture of vertebrae, according to care plan dated 4/11/12. R114 was discharged from the facility on 7/20/13, according to the facility discharge Minimum Data Set assessment. The facility identified R114 on the quarterly Minimum Data Set, an assessment dated 6/26/13, to have had one fall with injury since last assessment. Review of the facility Safety risk evaluation dated 10/5/12, identified R114 had history of multiple falls, diagnosis of dementia, and had chair alarms and pad; and review of evaluation dated 6/26/13, identified resident had recently had falls, used grab bars and bed sensor alarm. During interview on 3/14/14, at 4:00 p.m., registered nurse-A (RN-A) stated the facility had no other fall risk assessments for R114. Document review of resident care plan dated 4/11/12, revealed R114 was at high risk for falls related to history of multiple falls, with interventions that included room by nurses station, use toilet before and after meals, bed lowest position, tab alarm on, wear socks not nylons, and when restless meet all needs. Document review of facility Vulnerable Adult Reporting Form dated 7/21/13, revealed the following: On 7/20/13, at 2:20 p.m., R114 was observed in a squatting position between the foot of the bed and a chair. After returned to bed, R114 voiced pain in right hip. R114 was transferred to	F 226		

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F 226	Continued From page 8	F 226		

hospital for evaluation and determined to have a right femur fracture. R114 had a wheelchair pull tab alarm which did not sound. It was determined that the alarm was attached to resident but the cord was wrapped under the gauge of the portable oxygen tank and did not sound. Document review of the same report revealed the administrator was notified of the incident the next day by email on 7/21/13, at 11:55 a.m.; and designated state agency notified 7/21/13, at 12:00 p. m.

During interview on 3/14/14, at 2:20 p.m., director of nursing stated she expected staff to notify her and the administrator immediately of allegations of abuse and neglect. Director of nursing stated email messages go directly to their telephone and they receive the message right away.

During interview on 3/14/14, at 5:00 p.m., the administrator verified she and the designated state agency were not notified of the 7/20/13, incident until 7/21/13. She stated she did not know why she and the designated state agency were not immediately notified of the allegation of abuse and neglect.
R40's nursing progress note revealed that on 2/20/14 at 12:58 p.m. F-A accused a staff member of causing bruising to R40's right axillary area. The progress note indicated it was very evident that the bruise was due to R40's constant leaning in the wheelchair and pushing the area against the armrest. The nurse documented, it would be impossible to prevent bruising to this area due to the manner in which the resident sits in the chair. The wheelchair arm rests are padded, however the resident continues to ram her side into the arm rests and leans over the side of the chair causing pressure and bruising.

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F 226	Continued From page 9	F 226		

The nurse explained this to the family and they accepted the explanation. However, the nurse did not follow the abuse neglect policy and report the allegation immediately to the administrator and to the designated state agency.

On 3/14/14 at 9:25 a.m. the director of nursing (DON) indicated after the resident had a fall on 2/5/14 we were monitoring her bruising on the right axillary area which was a substantial area covered. When the family reported the bruising on 2/20/14 and accused a staff member of causing bruises to the right axillary area the DON did not investigate the allegation further. No staff members were interviewed. She agreed she should have done that. She was unsure if the administrator was notified.

On 3/14/14 at 10:00 a.m. registered nurse (RN)-C produced a document which she verified had been created on 3/14/14. The document indicated RN-C spoke to two different staff members who indicated the bruise was inflicted by R40's constant leaning to the right in her chair. No further investigation was conducted and the DON, administrator were not notified and neither was the state agency.

On 3/14/14 at 10:05 a.m. the DON indicated neither she nor the administrator was notified of the incident and they should have been.

On 3/14/14 at 10:39 a.m. social worker (SW)-A was interviewed. She was aware of the allegation on 2/20/14 and spoke to the nurse manager. We concluded the bruise was from the resident leaning to the right side. No interviews of any staff members were conducted. She agreed they failed to thoroughly investigate the bruises reported by

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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

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F 226	Continued From page 10 the family member as having been inflicted by the staff. The state agency was not notified.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		4/26/14

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 ______	03/17/2014

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

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F 272	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop comprehensive assessments for 1 of 4 residents (R25) for dental concerns. Findings include: R25 had loose dentures which were not identified on R25's comprehensive annual Minimum Data Set (MDS) an assessment of current health needs. Observation and interview with R25 and family (F)-B on 3/11/14 at 10:13 a.m. revealed concerns with loose fitting dentures. Resident indicated since being sick and losing weight her dentures don't fit anymore. F-B agreed and stated, "Mom loads them up with Polident but she needs them to be realigned. We have no insurance so what are we to do?" The staff indicated no concerns on the annual MDS dated 11/19/13 and the quarterly MDS 2/18/14, in the dental section which identified broken or loose fitting full or partials dentures. Three comprehensive nursing assessments dated 11/15/13; 1/27/14 and 3/2/14 identify the resident as having upper and lower dentures. All three assessments indicated the dentures fit well. Under the section of last known dental exam the nursing assessment dated 1/27/14 indicated	F 272	A Comprehensive dental assessment was completed (3/13/14 & 3/14/15) for R25. On 3/13/14, a Dental appointment was arranged for March 25th for R25. Care plan updated for R25 on 3/26/14. A Dental Care Assessment Policy was created on 4/2/14. Comprehensive Dental assessments for all residents on East unit were completed by 3/26/14. Comprehensive Dental assessments for all residents on west unit were completed by 4/14/2014. The Dental Care Assessment Policy was revised on 4/2/14. Formal education to all nursing staff at in-service occurred on 4/3/14 regarding the updated Dental Assessment Policy, and the updated Comprehensive Oral/Nutritional Assessment. PCC Committee updated the Comprehensive Oral/Nutritional Assessment that went live on 4/5/14. A Comprehensive dental assessment will be completed quarterly for all residents. An audit will be completed monthly to verify that an assessment has been completed for each resident on a quarterly basis for 3 months. Process will be reviewed at QA meeting on 5/20/14.	

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F 272	Continued From page 12 resident refused dental consults on 12/16/2010. No further dental consult requests were available. Interview with resident on 3/13/14 at 3:10 p.m. indicated she told staff about the loose dentures, but she does not remember who she told. She proceeded to open her mouth and show me how loose the dentures were and then took them out of her mouth. Observed to be very loose and when she opened her mouth (the bottoms) were not fitting to the gum. She indicated they have been loose since I lost so much weight. Weight records reveal resident had lost 27 pounds in the last five months. On 3/12/14 at 4:00 p.m. Registered nurse (RN)-C was made aware of the dental concerns and on 3/13/14 made an appointment for the resident to be seen. On 3/14/14 at 1:50 p.m. the director of nursing (DON) was interviewed about dental concerns. DON verified that the policy was not followed if the resident ' s dentures were so loose. The policy and procedure titled, Care of Dentures, dated 2/2/09, directed staff to inspect resident ' s mouth and assess denture fit and report ill-fitting dentures.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/26/14

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F 278	Continued From page 13 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to complete an accurate bladder assessment for 1 of 3 residents (R95) reviewed for urinary incontinence. Findings include: R95 had been assessed to be incontinent of urine due to urine spilled from urinal and in actuality was continent of urine and still is continent of urine. R95 was admitted on 10/17/13 with diagnosis of Parkinson's disease according to the admission	F 278	A Bowel and Bladder Assessment was completed on 3/21/14 for R95. A Bowel and Bladder Assessment be completed for all residents by 4/26/14. Formal education to nursing staff occurred at in-service on 4/3/14 on the updated Bowel and Bladder Assessment. Provided licensed nursing staff informal education regarding assessment accuracy, and coordination on 4/3/14. PCC Committee updated Bowel and Bladder Assessment that went live on 4/5/14. Nurse completing assessment will initial in the B&B assessment box when completed with	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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F 278	Continued From page 14 physician orders. The admission Minimum Data Set (MDS) dated 10/23/13 identified the resident as having occasional incontinence. The quarterly MDS dated 1/16/14 identified the resident as being frequently incontinent. The comprehensive nursing assessment dated 10/17/13 indicated the resident was wet 1-2 times daily during the day time. The comprehensive nursing assessment dated 1/10/14 indicated the resident was wet more than once a shift during the day and night time. Resident was observed on 3/11/14 at 4:05 p.m. in bed with urinal at bedside. Resident indicated when he has to urinate he is able to use the urinal and the staff empties it. He said that works well. He said he use to wear a brief but does not do so any longer. The care plan developed 10/17/13 indicated the resident had self performance deficits as a result of his Parkinson's disease and indicated resident was incontinent at times and does not like to be changed. The care plan directed staff to provide assistance with toileting, and changing. He does not like to be changed. Resident was observed in bed on 3/12/14 at 7:35 a.m. He was not in a very good mood and did not wish to have me in the room. At 7:50 am. nursing assistant (NA)-A was interviewed She indicated he can be very cantankerous during the day. He likes only certain aides and he is very particular. She said he uses the urinal and is always continent. Sometimes he may spill a little but he is not incontinent. He does not wear a brief and uses a pad under him for bowel movements. He refuses to get up and it is very difficult for him to	F 278	quarterly or annual assessment. Will be monitored monthly for three months to confirm that an assessment was completed quarterly for each resident. Process will be reviewed at QA meeting on 5/20/14.	

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F 278	Continued From page 15 use his bedpan. On 3/12/14 at 9:36 a.m. interview with registered nurse (RN)-A regarding the 10/17/13 admission MDS coding of urinary incontinence from occasional incontinent, to frequently incontinent on the quarterly MDS dated 1/10/14. She indicated in the look back period he was incontinent 9 times. She was unsure if that was spillage when trying to use urinal or actual incontinence. She did not know if spillage made him frequently incontinent but she did say it takes more time for staff to clean him up and change the pad or linen. Interview with licensed practical nurse (LPN)-B on 3/12/14 at 10:29 a.m. about incontinence for R95. She indicated he was not incontinent however he spills his urinal. Interviews with (NA)-B and (NA)-C on 3/12/14 at 10:45 a.m. revealed resident was not incontinent but spilled his urinal. On 3/13/14 at 11:45 a.m. RN-A verified spillage of urine was not incontinence and the admission assessment was incorrect.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		4/26/14

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F 279	Continued From page 16 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions for dental services for 2 of 4 residents (R44, R46) reviewed with assessed dental needs. Findings include: R44 was observation on 3/10/14, at 6:19 p.m., to have broken teeth on lower gum line. Observation on 3/12/14, at 11:10 a.m., with registered nurse (RN)-B revealed R44 had three broken teeth on lower gum line. Document review of R44's quarterly comprehensive nursing assessment dated 2/5/14, identified full upper denture, broken and carious teeth, own lower teeth with a few missing. R44's care plan print date 3/12/14, had not oral care interventions identified.	F 279	A Comprehensive dental assessment was completed for R44 and updated care plan on 3/12/14. A dental appointment has been scheduled for 3/27/2014. Completed a Comprehensive dental assessment for R46 and updated care plan on 3/21/14. The Comprehensive Dental assessments and care plan updates for all residents on East unit were completed by 3/26/14. Comprehensive Dental assessments and Care plan updates for all residents on west unit were completed by 4/14/2014. The Dental Care Assessment Policy was revised on 4/2/14. The Comprehensive Care plan Policy was updated on 4/1/14. Formal education to all nursing staff at in-service occurred on 4/3/14 regarding the updated Dental Assessment Policy, the new Comprehensive Care Plan Policy, and the updated Comprehensive Oral/Nutritional Assessment. PCC Committee updated comprehensive dental assessment that	

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

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F 279	Continued From page 17 During interview on 3/12/14, at 11:10 a.m., RN-B verified R44's comprehensive nursing assessment dated 2/5/14, identified full upper denture, broken and carious teeth, own lower teeth on lower, some missing and R44's care plan had not identified oral cares and problem of broken carious teeth. During interview on 3/12/14, at 1:08 p.m., director of nursing verified R44's comprehensive nursing assessment dated 2/5/14, identified full upper denture, broken and carious teeth, own lower teeth on lower, some missing and R44's care plan had not identified oral cares and problem of broken carious teeth. Director of nursing stated she would expect care plan would contain missing/broken teeth, how many, which ones and what goals would be, initiate dental care, comfort for dental, assess for pain, make sure going to dental appointments. Director of nursing stated her main concern was resident comfort. R46 had several missing teeth without care plan identification of missing teeth or interventions for care related to missing teeth. R46 was admitted to the facility to the facility on 9/24/13, with diagnosis that included cerebral vascular accident and diabetes mellitus according to the facility quarterly Minimum Data Set, an assessment dated 12/31/13. The facility identified R46 on the facility comprehensive nursing assessment dated 12/24/13, to have full upper dentures and broken or carious teeth. R46's care plan dated 12/31/13, revealed potential for nutritional risk related to diabetes, had upper partial, and interventions included to	F 279	went live on 4/5/14. A Comprehensive dental assessment will be completed quarterly for all residents. Will be monitored monthly for three months to confirm that an assessment was completed quarterly and the resident s care plan is up to date. Process will be reviewed at QA meeting on 5/20/14.	

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 279	Continued From page 18 monitor chewing and swallowing During interview on 3/12/14, at 7:12 a.m., licensed practical nurse (LPN)-D stated R46 brushed own teeth. During observations on 3/12/14, at 7:55 a.m., R46 had independently eaten breakfast and teeth were observed to be clean with no debris. During observations on 3/13/14, at 10:55 a.m., teeth were clean with no plaque or debris noted. During interview on 3/13/14, at 1:57 p.m., registered nurse-B (RN-B) verified the resident had several missing teeth, recently had tooth pulled on 2/28/14, due to abscess, and brushed own teeth after set up by staff. RN-B verified R46's care plan lacked identification and interventions for problem of missing teeth. Document review of facility Care Plans-Comprehensive policy dated 3/3/14, read, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." And "6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		4/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 19 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise and update the comprehensive care plan interventions for 1 of 1 resident (R40) reviewed who had severe episodes of self injurious behaviors and suicidal threats and failed to revise and update care plan interventions for ambulation for 1 of 5 residents (R66) reviewed for accidents. Findings include: LACK OF INTERVENTIONS DEVELOPED FOR SAFETY: R40 had ongoing behaviors of severe episodes of self injurious behaviors and threats of wanting to kill self or have staff kill her. However, R40 ' s	F 280	Care plan revised for R40 on 3/24/14 regarding restorative ambulation program. All residents care plans will be audited to confirm consistency with the appropriate restorative ambulation program by 4/26/2014. Formal education occurred to the Restorative Nurse on 4/10/2014 regarding the Restorative Program and that the assessments of residents are ongoing and care plans are revised as information and the resident and the resident s condition changes. Formal education was provided to all licensed nursing staff on 4/3/14 regarding the new comprehensive care plan policy and the importance of when changes that are made on resident care plan the aide	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280 Continued From page 20

care plan had not been updated to include interventions to address self injurious behaviors and suicidal threats.

R40 was admitted to the facility in 2009 and the physician progress notes dated 2/12/14 indicated in 2013, R40 had a cardiac arrest which resulted in traumatic brain injury (TBI) due to ischemic encephalopathy, and Cerebral Vascular Accident (CVA). The physician ' s note indicated the resident ' s behavior was very poor as the resident was very argumentative, yelled, screamed, and threw things. The physician wrote, "Clearly takes inappropriate risks and shows inappropriate behaviors with regard to her personal safety."

Observation of R40 on 3/11/14 at approximately 9:45 a.m. revealed R40 with call light bulb (air filled rubber bulb when pushed activated the light) in her mouth. Staff was alerted and staff member went and removed the call light bulb from the resident ' s mouth. At 11:25 a.m. R40 was observed in her room in a Geri chair with furrowed brow and a frightened or troubled expression on her face, and call light cord in her mouth. Staff was alerted and at 11:30 a.m. licensed practical nurse (LPN)-A, was interviewed about R40 and she indicated the resident had behaviors of chewing on the call light cord. She further indicated we switched out the other call light for this one so she doesn't chew and get the wires exposed. LPN-A was asked if anything had been tried to alleviate the chewing and she said a baby doll was tried but she threw it on the floor. She could not recall anything else being tried.

3/12/14 at 9:40 a.m. R40 was observed to be in bed. R40 indicated she had put on the call light

F 280

sheets also need to be updated. Aides need to report any updates needed to aide sheet to licensed nurse. An audit will be completed monthly for 3 months to confirm that the Restorative care plans will be revised as updated information is received from PT, OT & ST and when the resident s condition changes. Process will be reviewed at QA meeting on 5/20/14.

Resident was transported to ER for psych evaluation on 3/13/14 due to history of making statements about self harm and attempts at self harm. Sauer has declined to have resident return to facility due to history and potential to harm self. The acute hospital will place her in a more appropriate facility. Administrator communicated on 3/13 with resident Health care POA re: evaluation to occur at hospital. Administrator contacted POA for the 2nd time on 3/14/14 with update and plan to transport resident to a more appropriate facility. Suicide policy has been updated to reflect those residents that are attempting self harm will be evaluated to determine if Sauer Health Care is appropriate facility. The details of this resident s case will be reviewed at 5/20/14 QA committee meeting.

Suicide assessment created 3/21/14 and implemented on 3/24/14. A suicide assessment will be completed, by any licensed staff, at any time a resident voices or demonstrates thoughts of self-harm. A charge nurse will be notified immediately. Staff will document in a

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F 280	Continued From page 21 and they put me to bed because her back hurt. The call light was observed near her hand and some faint teeth marks were observed in the bulb. No pieces were missing from the bulb and no pieces were missing or rough edges were observed on the cord. On 3/12/14 at 10:45 a.m. two nursing assistants (NA)-B and (NA)-C, were interviewed and both indicated when the resident gets very anxious and wants someone with her, she will have attention seeking behaviors, such as calling out to people walking by, putting on her light, throwing things, and chewing on the call light. They acknowledged that when they go in and ask her what she wants she generally doesn't want anything other than for you to sit and hold her hand. They indicated she is the same way with her family. She wants them to visit but then gets mad when they have to leave and will yell and swear at them. They indicated a quiet room with music on sometimes helps the resident. Review of the medical record indicated the resident was hospitalized at the Grace Unit for behaviors in 10/22/13. The discharge summary dated 10/31/13 indicated the resident was admitted for severe agitation, paranoia, hallucinations, and combativeness. During the hospital stay the psychiatric evaluation dated 10/22/13 indicated she would often say to staff that she wished to die and requested, that staff kill her. The discharge diagnoses included advanced dementia with delusions and behavioral complications, dementia most likely neurodegenerative and vascular, mood disorder with severe anger, chronic depression and delirium related to the urinary tract infection which was treated with an antibiotic. Medications were	F 280	suicide assessment progress note following the assessment. Care plans will be immediately updated upon completion of the suicide assessment for any resident that voices or demonstrates thoughts of self-harm. Process will be reviewed at QA meeting on 5/20/14. Education to staff occurred at the mandatory all staff in-service on 4/3/14 re: Suicide Policy, Suicide Assessment Progress Note, and the Comprehensive Care Plan Policy. LSW will complete weekly audits of all residents charts by reviewing suicide assessment, suicide assessment progress note, and care plans weekly for 2 months then monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 280	Continued From page 22	F 280		

adjusted and she returned to the nursing home on Cymbalta 90 mg at 5 p.m. for mood disorder and behaviors, Tylenol 650 mg twice a day (bid) for pain (increased to four times a day (qid) on 11/26/13), Neurontin 200 mg bid for pain, (increased to 600 mg 1/2/14), Remeron 15 mg for mood disorder at bedtime (HS), Trazodone 100 mg at HS for sleep disturbances and Zyprexa 5 mg bid for psychotic disorder with hallucinations.

The quarterly Minimum Data Set (MDS) dated 2/20/14 indicated the resident had cognitive deficits. R40 was identified as having delusions and daily behavioral symptoms not directed towards others, which included self injurious behaviors and less than daily behavioral issues of verbal symptoms towards others.

The residents care plan current as of 3/9/13, indicated yelling out even when needs were met, manipulative behaviors, hallucinations and delusional thinking patterns. The care plan indicated the resident would swear, cry, throw things, and chew on the call light and cord. The staff determined there were no safety risks with chewing on the bulb and cord as there were no electrical wires running through the call light cord into the bulb. However, R40 ' s comprehensive care plan failed to address the ongoing safety risks of possible choking with the call light bulb in her mouth, wrapping the cord around her neck, attempting to hang herself on the u-bar on the bed, stuffing Kleenex, coins or plastic in her mouth.

On 3/13/14 at 10:35 a.m. the director of nursing (DON) was interviewed about safety concerns for R40. She indicated that the self-injurious behaviors should be identified in R40 ' s care

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 ______	03/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23	F 280		

plan.
LACK OF AMBULATION SERVICES RECOMMENDED BY PHYSICAL THERAPY:

R66's comprehensive care plan print date 3/13/14, identified actual activities of daily living (ADL) with self-care performance deficit related to diagnoses of dementia, Parkinson's disease, osteoporosis and chronic lumbago with intervention of but not limited to ambulation will be put on hold at this time. However, R66 ' s comprehensive care plan had not been developed to include restorative services to include ambulation after a physical therapy recommendation 2/18/14.

During interview on 3/12/14, at 7:58 a.m., occupational therapist verified Sauer Health Care Physical Therapy Department sheet dated 2/18/14 was current instructions for nursing to follow since R66 had been discharged from physical therapy.

Document review of R66 ' s Sauer Health Care Physical Therapy (PT) Department sheet dated 2/18/14, identified physical therapy follow through orders for rehab and nursing staff: restorative to ambulate with R66 one to two times daily with forward wheeled walker and minimum assist of one for distances up to eighty feet or as R66 tolerates.

Document review of west center CNA (certified nursing assistant) sheets dated 2/28/14, identified ambulation will be put on hold at this time and had not been revised to include restorative to ambulate.

Document review of R66 ' s progress notes dated

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 ______	03/17/2014

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 280	Continued From page 24 2/18/14, time of 12:31, identified restorative note, orders were received from PT to restart ambulation with nursing staff. The distance has been lowered from 200 feet to 80 feet or as tolerated. Will evaluate R66's ability to complete this before increasing back to baseline. During interview on 3/13/14, at 10:58 p.m., physical therapist stated the Sauer Health Care Physical Therapy Department recommendation sheet dated 2/18/14 for nursing staff contained directions for ambulation program R66 should be on and was what nursing staff should follow. During interview on 3/14/14, at 4:12 p.m., director of nursing stated CNA sheets are based off care plan and verified care plan had not been revised to include physical therapy follow through orders dated 2/18/14 for rehab and nursing staff: restorative to ambulate. Document review of the facility policy and procedure Care Plan-Comprehensive dated 3/3/14, read, "Policy Interpretation and Implementation 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		4/26/14

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 ______	03/17/2014

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

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F 282	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the care plan for transfers for 1 of 5 residents (R66) reviewed for accidents. Findings include: R66 was observed on 3/12/14, at 7:24 a.m., nursing assistant (NA)-F had placed gait belt around R66 torso and had transferred R66 using a walker, ambulated from bed to wheelchair. R66's Sauer Health Care Physical Therapy Department sheet dated 2/18/14, identified physical therapy follow through orders for rehabilitation and nursing staff: nursing to transfer (R66) with assist of two. R66's care plan print date 3/13/14, identified actual activities of daily living (ADL) self-care performance deficit related to diagnoses of dementia, Parkinson's disease, osteoporosis and chronic lumbago with interventions of but not limited to transfer using assist of two. Document review of west center certified nursing assistant (CNA) work sheet which contained R66 ' s cares dated 2/28/14, identified transfer assist of two staff. During interview on 3/12/14, at 7:32 a.m., nursing assistant (NA)-F verified she had transferred R66 by herself even though the CNA work sheet dated 2/28/14 identified R66 was to be transferred with assist of two. During interview on 3/12/14, at 7:58 a.m.,	F 282	Disciplinary write up completed for aide that failed to follow care plan while transferring resident R66. Care plan updated for R66 on 3/24/14 regarding ambulation/transfer assistance needed. The Comprehensive Care plan Policy was updated on 4/1/14. An audit will be completed by an RN during all shifts by 4/26/2014 to confirm that care plan is being followed with resident transfers. Formal education to all nursing staff occurred at the in-service on 4/3/14 reviewing the Comprehensive Care Plan Policy. Audits will be completed randomly on all shifts bi weekly for 2 months to confirm that the care plan is being followed with resident transfers. Process will be reviewed at QA meeting on 5/20/14.	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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

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F 282	Continued From page 26 occupational therapist verified Sauer Health Care Physical Therapy Department sheet dated 2/18/14 was current instructions for nursing to follow since R66 had been discharged from physical therapy. During interview on 3/13/14, at 10:58 p.m., physical therapist stated the Sauer Health Care Physical Therapy Department sheet dated 2/18/14 for nursing staff is program R66 should be on and was what nursing staff should follow. During interview on 3/14/14, at 4:12 p.m., director of nursing stated the CNA sheets are based off care plan and verified CNA sheet dated 2/28/14 and R66's care plan identified R66 was to be transferred with assist of two. Policy following care plan was requested on 3/14/14, at 4:12 p.m., from director of nursing. On 3/14/14, at 5:00 p.m., director of nursing stated she did not have a policy regarding following the care plan.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 323	Resident was transported to ER for psych	4/26/14

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 ______	03/17/2014

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

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F 323	Continued From page 27 review, the facility failed to identify the hazard related to the unsafe practice of placing a call light cord and/or bulb in the mouth, and wrapping the cord around the neck resulting in the risk for choking, aspiration and strangulation, for 1 of 1 (R40) resident with self-injurious behaviors and suicidal threats. This resulted in an immediate jeopardy (IJ) situation for R40. The IJ began on 11/25/13 when the facility became aware of R40 placing the call light cord and/or bulb in her mouth and chewing on it. According to the record, R40 had been observed on many occasions to put the bulb into her mouth and chew on it and the staff had not assessed the call light bulb as a potential choking risk for R40. In addition, on 1/21/14 at 2:08 p.m. R40 was observed to have wrapped the call light cord around her neck. Following the incident there had been no risk assessment of the continued use of the call cord for R40 completed, and R40 continued to use the call cord as observed on first day of survey. These findings were identified on 3/13/14 at 12:45 p.m. The administrator and director of nursing (DON) were notified of the IJ on 3/13/14 at 1:05 p.m. The IJ was removed on 3/14/14 at 11:00 a.m., but noncompliance remained at the lower scope and severity level of D which is isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R40 was observed on 3/11/14 at 9:45 a.m. while walking past her bedroom to have a rubber call light bulb in her mouth. Staff was immediately alerted by the surveyor and a staff member went and removed the call light bulb from the resident's	F 323	evaluation on 3/13/14 due to history of making statements about self harm and attempts at self harm. Sauer has declined to have resident return to facility due to history and potential to harm self. The acute hospital will place her in a more appropriate facility. Administrator communicated on 3/13 with resident Health care POA re: evaluation to occur at hospital. Administrator contacted POA for the 2nd time on 3/14/14 with update and plan to transport resident to a more appropriate facility. Suicide policy has been updated to reflect those residents that are attempting self harm will be evaluated to determine if Sauer Health Care is appropriate facility. The details of this resident s case will be reviewed at 5/20/14 QA committee meeting. Suicide assessment created 3/21/14 and implemented on 3/24/14. A suicide assessment will be completed, by any licensed staff, at any time a resident voices or demonstrates thoughts of self-harm. A charge nurse will be notified immediately. Staff will document in a suicide assessment progress note following the assessment. Process will be reviewed at QA meeting on 5/20/14. Education to staff occurred at the mandatory all staff in-service on 4/3/14 re: suicide policy, assessment, and progress note. LSW will complete weekly audits of all residents charts by reviewing suicide assessment and suicide assessment	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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

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F 323	Continued From page 28 mouth. At 11:25 a.m. R40 was observed in her room in a Geri chair with her brows furrowed and a distressed looking expression on her face, and was again observed to have the call light bulb in her mouth. Staff were again alerted by the surveyor and at 11:30 a.m., licensed practical nurse (LPN)-A was interviewed about R40 chewing on the call light bulb. LPN-A stated the resident had regular behaviors of chewing on the call light cord. LPN-A further stated they had replaced the call light with one that did not have electrical wires because R40 would chew on the cord and they did not want R40 to get an electric shock. LPN-A was asked if anything had been tried to alleviate the chewing and she said they had tried to use a baby doll for distraction, but R40 threw it on the floor. LPN-A could not recall anything else being tried. On 3/12/14 at 9:40 a.m., R40 was observed to be in bed and R40 told the surveyor she had just recently put on the call light and the staff had put her to bed because her back hurt. The call light was observed near her hand and faint teeth indentation marks were observed on the bulb. R40's record was reviewed and the facesheet indicated she had been admitted to the facility in 2009. A physician's progress note dated 2/12/14, indicated in 2013 the resident had suffered a cardiac arrest which had resulted in traumatic brain injury due to ischemic encephalopathy, and cerebral vascular accident (CVA). That physician note indicated the resident's behavior was very poor as the resident became very argumentative, yelled, screamed, and threw things. The physician had documented the resident, "clearly takes inappropriate risks and shows inappropriate behaviors with regard to her personal safety."	F 323	progress note weekly for 2 months then monthly for 3 months.	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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

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F 323	Continued From page 29 On 3/12/14 at 10:45 a.m., two nursing assistants (NA)-B and NA-C were interviewed and both indicated when the resident gets very anxious and wants someone with her, she will have attention seeking behaviors, such as calling out to people walking by, putting on her call light, throwing things, and chewing on the call light. They acknowledged that when they go in and ask her what she wants she generally doesn't want anything other than for someone to sit and hold her hand. These NAs stated she is the same way with her family, and wants them to visit but then gets mad when they have to leave and will yell and swear at them. They indicated a quiet room with music on sometimes helps R40 to calm down. Review of the medical record also indicated R40 had been hospitalized at a local behavioral health unit for treatment of her behaviors on 10/22/13. The discharge summary dated 10/31/13, indicated the resident had been admitted for severe agitation, paranoia, hallucinations, and combativeness. During the hospital stay the psychiatric evaluation dated 10/22/13, indicated R40 would often say to staff that she wished to die and requested staff kill her. The discharge summary identified discharge diagnoses including: advanced dementia with delusions and behavioral complications, dementia most likely neurodegenerative and vascular, mood disorder with severe anger, chronic depression and delirium related to the urinary tract infection which was treated with an antibiotic. In addition, the hospital discharge summary and subsequent physician orders indicated the resident's medications had been adjusted and upon return to the nursing home orders included: Cymbalta	F 323		

F 323 Continued From page 30 F 323

(antidepressant) 90 mg (milligrams) at 5 p.m. for mood disorder and behaviors, Tylenol 650 mg twice a day (bid) for pain (increased to four times a day (qid) on 11/26/13), Neurontin 200 mg bid for pain, (increased to 600 mg 1/2/14), Remeron 15 mg for mood disorder at bedtime (HS), Trazodone 100 mg at HS for sleep disturbances and Zyprexa (antipsychotic) 5 mg bid for psychotic disorder with hallucinations.

Nursing progress notes were reviewed from 11/1/13 to 3/11/14 and the staff documented numerous behaviors of chewing and putting call light cord into mouth, yelling, screaming, throwing objects at staff, swinging call light around trying to hit staff, chewing on call light cord, making statements that she wanted to die, refusing to eat, seeing food crawl up pant leg, etc.

Progress notes (PN) dated 11/25/13 at 5:56 p.m., indicated that R40 was observed chewing on her call light. Call light (round tap light) was replaced with a bubble type call light, which being more light weight would not cause injuries when resident swung the light around. Staff offered her 1 to 1 monitoring, and redirection which was effective for a short time. The call light was pinned to the resident's chair, but the resident unpinned it, and began chewing on the bulb part of the call light.

12/11/13 at 2:12 p.m., the PN indicated staff observed R40 biting on the bulb end of her call light. The RN supervisor was notified of the episode and the resident was removed from the room. Staff offered the resident 1 to 1, redirection, food and drink. Unsure if the interventions were effective.
1/3/14 at 9:34 p.m., PN indicated R40 had pulled

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 ______	03/17/2014

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

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F 323	Continued From page 31 two dimes out of her mouth after BINGO. There were no interventions developed to prevent R40 from having access to coins to prevent risk of chocking. 1/4/14 at 2:13 p.m., PN indicated R40 was chewing on call light cord and bulb, staff indicated they would remove it (call light) from R40's hand and clip it to the blanket within reach. R40 would pull it from the blanket and put in her mouth again. Staff offered the resident 1 to 1 monitoring, reassurance, assessed for pain which were all ineffective. 1/7/14 at 2:08 p.m., PN indicated R40 was putting call light cord in her mouth, shaking it, and growling at staff when they tried to remove it. Staff offered the resident 1 to 1, reassurance, and assessed for pain. However the note further indicated staff were unsure if the interventions were effective. 1/8/14 at 6:22 p.m., PN indicated that staff were walking past the resident's room and noticed resident's feet firmly planted on the ground and the resident had lifted her torso up and rested her neck on the grab bar. R40 stated to the staff that she had wanted to kill herself, but denied having a plan to harm herself. R40 indicated she wanted to get out of there and get to her baby. Was asked again if she was going to harm herself to which resident replied, "No you are going to kill me." A call was placed to the physician, after consultation with the social worker and a nurse on duty. Resident was to be sent into the emergency room. The Patient/Resident Care Summary report dated 1/8/14, which had been sent with the emergency medical service personnel (EMS) to the hospital emergency room included, "Threatened to hang herself with call light cord [there is no documentation to support this statement in R40's	F 323		

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 ______	03/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32	F 323		

records], sucks on call light, says staff is going to kill her. Tried to strangle herself by hanging her head over the grab bars on her bed, and non-stop threats to kill herself. Behaviors have escalated since the discontinuation of Zyprexa."
The Emergency Room Report, dated 1/8/14, received by the facility upon her return, indicated R40 had been seen in the emergency room for suicidal threats and acting on these threats. It was discovered R40 had a urinary tract infection (UTI) at this time. In the emergency room the resident denied wanting to die. The nursing home reported to the EMS that the resident, "tried to strangle herself by hanging her head over the grab bars on her bed, and nonstop threats to kill herself." Emergency Room Report indicated behaviors have escalated since discontinuing the Zyprexa. After consulting with resident's physician and family it was decided to start Risperdal (antipsychotic) 0.5 mg bid, also to start on an antibiotic for the UTI, and send the resident back to the nursing home.
1/13/14 at 10:38 a.m., PN indicated staff was walking past the resident's room and noted the resident with her shirt pulled up over her head. When asked what she was doing, the resident responded, "Trying to kill myself." Staff sent a message to social services.
An eight page fax dated 1/13/14, with progress notes describing R40's behaviors was sent to the attending physician regarding the attempts to harm herself on 1/8/14 when trying to hang self on positioning bar connected to the bed. Staff asked for any ideas to help with the behavioral issues. Staff indicated Behavioral Health Agencies and/or hospitals had been contacted at two different places but they both were unable to assist with the resident's behaviors. The physician responded back with orders to

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F 323	Continued From page 33 discontinue the Risperdal and restart the Zyprexa at 10 mg bid along with Methadone (an opioid used to treat moderate to severe pain) 5 mg qid. 1/14/14 at 6:02 p.m., PN indicated R40 clenched down on call light with teeth and refused to let go. When staff tried to assist the resident she scratched the staff and wouldn't let go of them. 1/15/14 at 8:00 a.m., PN noted R40 was biting on her call light cord and refused to take it out of her mouth. No interventions were identified as being implemented. 1/17/14 at 1:45 p.m., PN indicated staff noted resident to be chewing on bedside rubber mat in her room and to have chewed off two chunks from the mat. Mat was taken away from R40 and placed in the bathroom. When mat was observed on 3/14/13 at approximately 3:00 p.m., the mat which was about 6 feet long by 2 feet wide was noted to have 5 areas that were in the shape of a mouth bite where the rubber had been removed. 1/20/14 at 1:37 p.m., PN indicated that R40 was provided a Kleenex with which to wipe her face, but shoved it in her mouth. Staff observed her to have put a small plastic bag from her garbage can into her mouth and her call light in her mouth. Staff indicated that R40 wouldn't take the call light out of her mouth so staff told R40 they would go and assist someone else and come back later and then the resident spit her call light out of her mouth. PN do not indicate what happened to the Kleenex or plastic bag. 1/21/14 at 2:08 p.m., PN referenced that R40 had the bulb for her call light in her mouth and wouldn't let go and one episode noted where R40 had call light cord wrapped around her neck. Staff offered the resident 1 to 1 monitoring. Even though the call cord was wrapped around R40's neck, the facility had not assessed the cord for a safety risk nor developed interventions to prevent	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 323	Continued From page 34 the possibility of R40 from again wrapping cord around neck. 1/21/14 at 2:31 p.m., PN indicated R40 placed the bulb of the call light in her mouth and had it clenched in her teeth. The resident would not let go of the bulb. The staff member offered to take her to breakfast and attempted to pull on the cord which the resident would not release. After a second staff member came, and after several attempts, the resident did let go. 1/23/14 at 1:46 p.m., PN indicated R40 to be chewing on call light bulb. 1/24/14 at 1:01 p.m., PN indicated R40 continued to take call light bulb and putting it in her mouth and that staff had a hard time getting her to let go of it. 2/5/14 at 2:05 p.m., PN indicated that R40 got a hold of her daughter's keys and was chewing on them; also noted to be chewing on call light and cord. 2/13/14 at 1:46 p.m., PN indicated R40 chewing on the call light cord. 2/14/14 at 2:02 p.m., PN indicated R40 chewing on call light cord and swinging the cord 2/19/14 at 1:56 p.m., PN indicated that R40 continues to chew on call light daily. 2/27/14 at 2:00 p.m., PN indicated R40 chewing on cord was the only behavior exhibited. Staff offered 1 to 1 and redirection which the PN indicated were effective. 3/1/14 at 2:19 p.m., PN indicated R40 was chewing on the call light cord. Staff offered 1 to 1 and encouragement which were not effective. 3/8/14 at 5:35 a.m., PN indicated R40 had cord from call light in her mouth and did not want to let it go. 3/11/14 at 2:02 p.m., PN indicated R40 had several episodes of chewing on call light cord and bulb during shift. Staff offered 1 to 1 monitoring,	F 323		

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 ______	03/17/2014

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

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F 323	Continued From page 35 and assured resident needs were being met. Staff offered food/drink and redirection none of which were effective for any length of time. The annual Minimum Data Set (MDS) (an assessment to determine current health needs) dated 8/21/13, indicated the resident had cognitive deficits. A Brief Interview for Mental Status (BIMS) indicated a score of 8 out of 15 which was indicative of cognitive impairment. According to the MDS, R40 was identified as having hallucinations and delusions, having daily behavioral issues of verbal symptoms towards others, daily behavioral symptoms not directed towards others which included self injurious behaviors. The Care Area Assessment (CAA) completed 8/21/13, indicated R40 had delusional thoughts, screams, cries daily and wishes she were dead. Many times during the day she needed 1 to 1 monitoring because she screams, cries out, "I want to die." The quarterly MDS dated 2/20/14, indicated the resident had a BIMS score of 7 which indicated cognitive deficits. She again was identified as having delusions, daily behavioral symptoms not directed towards others which included self injurious behaviors, and less than daily behavioral issues of verbal symptoms towards others. R40's comprehensive care plan, current as of 3/9/13, indicated yelling out even when needs were met, manipulative behaviors, hallucinations and delusional thinking patterns. The care plan indicated the resident would swear, cry, throw things, and chew on the call light and cord. The staff determined there were no safety risks with chewing on the bulb and cord as there were no electrical wires running through the call light cord into the bulb. The care plan directed the staff to keep routine consistent and try to provide	F 323		

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 ______	03/17/2014

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F 323	Continued From page 36 consistent care givers. Staff was to monitor, document and report ongoing signs and symptoms of anger, irritability, crying, agitation, and suicidal ideation's. Staff were directed to provide 1 to 1 monitoring if necessary which would usually change her mood, along with music. The care plan indicated R40 had impaired thought processes, however, she was able to convey her feelings to the staff and did so readily. The care plan directed staff to provide two call lights due to resident's risk for falls with rapidly changing moods and attempts to stand. Observation on 3/13/14 at 2:55 p.m., indicated R40 was observed with only one call light available. On 3/12/14 at 9:55 a.m., maintenance (M)-A and M-B were interviewed. They both indicated they had observed R40 chewing on the call cord and the bulb, but felt the current call light was safe, because it had no electrical wires running through it. During interview on 3/12/14 at 4:00 p.m., registered nurses (RN)-C and RN-D were asked about R40's self injurious behaviors and safety. Both RN-C and D indicated they were aware of the behaviors exhibited by R40 in regards to the chewing of the call light. In fact, the regular hard call light was replaced when the resident would swing it around and injure self and others. She then was given the gray flat plate call light, but she chewed on that causing fraying. RN-C indicated she did not think she had swallowed any of the pieces hanging from the flat plate. R40 was then given the soft bulb call light which she currently had. The current call light has no wires to expose so the resident was considered safe from getting an electric shock. However, the	F 323		

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 ______	03/17/2014

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F 323	Continued From page 37	F 323		

facility did not consider the possibility of choking on the call light bulb, or parts of the bulb as a potential hazard.

On 3/13/14 at 10:35 a.m., the director of nursing (DON) was interviewed about safety concerns related to self-injurious type behaviors and threats of wanting to die for R40. She indicated staff had done a lot to protect the resident and keep her safe. The DON stated the call light had been changed out three times and she thought the one R40 had now was a safe one with no electrical cords. When the DON was told of the observations of R40 having the entire bulb in her mouth, the chewing on the call light cord and possible choking risks, the DON agreed that could be a choking risk. She further agreed that R40 had been putting the bulb in her mouth and chewing on the cord for some time, but was unsure how long. She was only aware of one time that R40 had put the call cord around her neck and stuffed non-edible items in her mouth.

On 3/14/14 at 10:25 a.m. the social worker (SW)-A was interviewed. She was aware of the call light being put around her neck and trying to choke self on the grab bar. She indicated after the incident with the grab bar she was called and she directed staff to watch her closely and to send her to the emergency room, which they did on 1/8/14. The behavior unit at Winona hospital would not admit the resident because she was too high of care needs and she was brought back to the home. The grab bars were removed from R40's bed following the attempt to choke self. SW-A indicate she contacted alternative placement the day after R40 returned from the emergency room however, no one would take the resident because of her behaviors and high

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 ______	03/17/2014

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

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F 323	Continued From page 38	F 323		

physical needs. SW-A indicated she had tried about three places following her emergency visit (January 8, 2014) but nothing recently. No further information was provided in regards to intervention for R40's behaviors and safety concerns. Also SW-A indicated chewing on the call light cord and the bulb was discussed with the interdisciplinary team (IDT). They talked about the chewing issue, but due to dignity issues they did not pursue other chew items. SW-A stated they only looked at the safety in regards to the call light cord not having electrical wires running through it and not in regards to the resident choking on the bulb or being able to bite off pieces and swallow them or wrapping the cord around neck. She agreed choking would be a risk.

An interview was attempted with the medical director on 3/14/14 at 12:00 p.m. however, the clinic staff indicated he was unavailable for 2 weeks.

On 3/14/14 at 12:45 p.m., the resident's medical doctor (MD)-H was called. He indicated he was aware of all of her behaviors and he felt they were not credible self harm attempts. He believed them to be attention seeking behaviors. He felt staff had done everything possible for the resident but what the resident needed was constant 1 to 1 and he did not know where the resident could receive that kind of care. He indicated the resident never needed resuscitation for any of these incidents and he felt the situations had been taken care of.

On 3/14/14 at 2:25 p.m., a phone interview with licensed practical nurse (LPN)-D about R40 was completed. LPN-D had been working on 1/8/14, and recalled the incident with the resident and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING ______ B. WING ______	03/17/2014

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 323	Continued From page 39	F 323		

grab bar. She indicated she was walking by the room and observed R40 with feet firmly planted on the floor. The resident was holding onto the grab bars with her neck on top of the bar putting her weight and neck down on the bar. She described how the resident's eyes looked different, almost detached. She stated the resident's color did not appear blue. She indicated it took a while to get her hands pried loose and LPN-D said R40 had said she wanted to die. The resident's breathing did not seem to be labored. After R40's hands were removed from the grab bar, they laid her down and her face became reddened. LPN-D thought it was more emotional as the resident began to cry.

The policy and procedure titled, Suicidal Ideation Policy revised 1/2/14, directed the staff if resident verbalized thoughts of self harm it should be reported immediately to the charge nurse or social services. The nurse or social worker would assess the resident and situation for potential for harm. If the resident does have a plan of self harm staff should assess for causes, monitor the resident and update the care plan. If the resident has an attainable plan of self harm the attending physician and power of attorney (POA) need to be notified immediately to determine the next steps and the resident should be sent to the emergency department for an evaluation.

The immediate jeopardy that began on 11/25/13, was removed on 3/14/14 at 11:00 a.m., when the facility had implemented a corrective action plan. The corrective action plan included, immediate 1 to 1 supervision for R40, education of staff, removal of the call cord from R40's room, and facility review of their Suicide Precaution's Policy. In addition, R40 was sent to the emergency room

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 323	Continued From page 40 on 3/13/14 for evaulation, and was admitted to the acute care hospital for observation until a psychiatric facility could be found to admit her for further evaluation and treatment. Noncompliance remained at the lower scope and severity of a D, as the facility had not had time to fully assess environmental risks, to develop additional interventions, assess whether other interventions would be effective, review and/or develop policies and procedures in regards to environmental risk, and provide more specific education to staff in regards to assessing and reassessing environmental risks and behavioral risks that could potentially cause harm to residents.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide necessary care and services related to significant weight loss for 1 of 3 residents (R58) reviewed for weight loss. Findings include:	F 325	RD saw resident R58 on 3/12/14 and will follow up monthly with resident for 3 months. Prior to the arrival of the state survey being completed within our facility, the following was completed regarding R58	4/26/14

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 ______	03/17/2014

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SAUER HEALTH CARE	1635 WEST SERVICE DRIVE WINONA, MN 55987

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F 325	Continued From page 41 R58 was admitted on 9/9/13 on the admission record, with diagnoses including dementia, depressive disorder, atrial fibrillation, tremor, osteoporosis, coronary artery disease, and hypertension. The Weights and Vitals Summary section of the record showed the resident weighed 142.8 pounds (lbs.) on 9/11/13,141 lbs. on 1/1/14, and 123.4 lbs. on 3/12/14. A loss of 19.4 lbs. in six months or 8.6 percent (%.) The nutritional assessments in the record, Section K of the admission Minimum Data Set completed by the facility's dietary manager on 9/20/13 and 12/12/13, both showed that the resident weighed 143 lbs. and had no issues with significant weight loss. There were two entries by the facility's registered dietician in the progress notes, dated 10/9/13 and 3/12/14. The 10/9/13 entry read, "... [R58] appears to be at a good weight. Will continue the BID [twice daily] supplements with weight goal of 140-150# [lbs.] Weight is fine. Will follow as needed." The 3/12/14 entry read, "Notified of [R58 ' s] weight loss. Wt. 123.4# (3/12). Significant weight loss at 30 and 90 days. He does have some edema which fluctuates. Remeron [an antidepressant] was tried with hopes of increasing his appetite but it wasn't effective. MD [medical doctor] is aware of the weight loss. Meal intake is poor at 0-25%. Continues to eat independently once meal is set up. No chewing or swallowing issues have been noted recently. Is drinking 25-50% of his BID supplements. Will continue with these and will follow monthly. Weight loss is likely related to progression of his dementia."	F 325	significant weight loss: On 2/11/14: NP addressed weight loss, and increased Remeron from 15mg QD to 30mg QD for weight loss. On 2/25/14: Increased Remeron dose confirmed not effective, reviewed with PMD Dr. Kelly, and decided to D/C Remeron entirely. All medications reviewed for possible causative factor(s) for weight loss during this review. Dr. Kelly did not dictate a note (this was verified with medical records at Winona Health). On 3/11/14: weights and Remeron D/C evaluated by RN-stability in weights was noted x 2 weeks. Care plan interventions were updated to reflect all interventions, and failed trial of Remeron on 2/25/14 and 3/24/14. Goal was changed to reflect that it is expected for Bernie to lose weight r/t dementia. RN managers continue to address weights/vitals alerts portal on a daily basis. Any resident with an unexplained/unexpected weight loss is to be reviewed at biweekly skin/weight/meal meeting. Dietary manager also then consults with dietician for recommendations on any resident that has an unexplained/unexpected weight loss. Skin/weight/meal meeting minutes will include tracking for residents with significant weight loss or potential for. Formal education to all nursing staff was provided at the in-service on 4/3/14 re: Comprehensive Care Plans Policy, Nutrition (impaired)/Unplanned Weight Loss-Clinical Protocol, and the importance of when changes that are made on resident careplan the aide sheets also need to be updated. Aides	

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	245102	A. BUILDING ______ B. WING ______	03/17/2014

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

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F 325	Continued From page 42 No documentation a medical doctor was aware or assessed R58 ' s significant weight loss neither was located in R58 ' s record nor was any provided by the facility. A dictated note from a nurse practitioner (NP)-A, dated 2/11/14, read, "He snacks quite a bit and nursing has noted a weight decrease from 141 to 133... Nursing notes as above his eating varied. He snacks mostly... His appetite varies, weight declined. He is on Remeron. We can increase this to 30 mg daily, and see if we can get his appetite a bit improved." The current physician orders included a diet order for mechanical soft diet with thin liquids, and Health Shake supplement twice daily with breakfast and supper, both ordered on 9/9/13. Review of the resident's current plan of care, dated 9/27/13, revealed one focus related to weight loss that read, "[R58] has the potential to be at nutritional risk r/t [related to] varying intakes at times. Current intakes vary 50-75% with meals being consumed in the MDR [medication documentation record]. [R58] has an MD order to receive nutritional supplements BID for health maintenance and weight loss prevention. " The goals listed for this focus read, "[R58] will maintain adequate nutritional status as evidenced by maintaining weights 140-150#, consuming at least 75% of all meals through review date." The interventions for this focus read, "Offer [R58] health supplements with breakfast and supper. On average, [R58] drinks 25-50% of his shakes that are given. Provide and serve (Mechanical Soft) diet as ordered. Good fluid intakes through out [sic] the day. Offer snacks as resident will accept. Healthshakes 2 x daily [sic]. Maintain good satisfaction with meals/food."	F 325	need to report any updates needed to aide sheet to licensed nurse. All nutrition sections in residents care plans will be reviewed and updated by 4/25/14. Dietary Manager will run monthly weight report every 2 weeks to review for residents with significant weight loss (-5% in 30 days/-10% in 180 days). Will review every 2 weeks for 3 months. Process will be reviewed at QA meeting on 5/20/14.	

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 ______	03/17/2014

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

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F 325	Continued From page 43 When interviewed on 3/12/14, at 9 a.m. the registered dietician (RD) stated that R58 was not on her high risk weight loss list and she was unaware of his weight loss. When asked how she becomes aware of a resident's weight loss, she stated that the dietary manager informs her of resident weight loss. The RD then showed the surveyor her high risk list and R58 was not on the list. When asked how often she does dietary assessment on residents, the RD replied that she does a nutritional assessment on admission and annually. She only does assessments more often if there is weight loss, a wound, or after admission to the hospital. She stated that she does not do a quarterly nutritional review unless there is a problem. She also stated that the dietary manager assesses the resident's food likes and dislikes. When interviewed on 3/12/14, at 10 a.m. the dietary manager stated her department monitors resident intakes and weights, and the dietician is responsible for making her high risk list. She also stated that R58 had not been on that list, but will be immediately, and there is an interdisciplinary meeting in the facility every two weeks during which the residents on this list are discussed. She explained that the registered dietician does the annual assessments and the dietary manager does the quarterly reviews. During interview on 3/12/14, at 9:30 registered nurse (RN)-C, the clinical manager for R58's unit, stated that she attends the meetings where the residents on the nutritional high risk list are discussed every two weeks, and she had not been aware that R58 was not on that list and that this resident was taking supplements. She explained that she thought weight loss would be	F 325		

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 ______	03/17/2014

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

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F 325	Continued From page 44 expected with this resident due to his dementia.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately and clearly identify indications (resident specific symptoms) for use of an as needed (PRN) anti-anxiety medication for 1 of 5 residents (R66) reviewed for unnecessary medications.	F 329	A GDR form for Ativan was completed by Consultant Pharmacist for R66 on 3/19/14. GDR form was put in rounds book for NP on 3/25/14. Nurse Practitioner has reviewed need for Ativan during rounds on 3/25/14. Resident care	4/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 45 Findings include: R66 had been admitted on 7/30/12 according to the admission record dated 3/14/14, identified diagnoses that included but not limited to dementia, dysthymic disorder (Depressive mood disorder) and paralysis agitans (Paralysis agitans, which literally means " shaking palsy, " is another term for Parkinson ' s disease.) R66's quarterly Minimum Data Set (MDS) dated 2/17/14; identified brief interview of mental status (BIMS) had been five out of fifteen and indicated severe cognitive impairment and no behaviors. R66's physician orders dated 2/10/14, identified an order for lorazepam (Ativan) (antianxiety medication) 0.5 mg (milligrams) PRN, give prior to home outings with family, family requests this to be given on a regular basis for dysthymic disorder. Document review of R66's physician nursing home notes dated 12/17/13, 11/7/13 and 10/14/13 had no documentation regarding Ativan use. Physician nursing home note dated 8/5/13, identified does receive PRN Ativan primarily when he goes on outings with family members as they specifically request this medication. R66's care plan print date 3/13/14, identified uses Ativan, an anti-anxiety medication to decrease the feelings of anxiety, behaviors include anxiety related to riding in car with family, has experienced increased anxiety when going out with family, therefore, Ativan is given prior to leaving with family and interventions that included but not limited to administer Ativan to manage anxiety as ordered by physician, this is a prn	F 329	plan updated on 4/18/14. On 3/25/14, NP accepted GDR to .25mg PRN when resident goes on family outings or appointments. All care plans for resident s who receive a psychotropic medication will be reviewed and updated if necessary ensuring all targeted behaviors and interventions are listed. Psychotropic drug monitoring meeting continues to meet monthly with IDT and Consultant Pharmacist to review residents due for GDR. At psychotropic during monitoring meetings, IDT reviews resident s targeted behaviors and evidence based data through staff documentation and Consultant Pharmacist then completes GDR form with information on targeted behaviors exhibited for provider to review. Following psychotropic drug monitoring meetings, Nurse Manager or designee will complete progress note indicating targeted behaviors, stating if targeted behaviors have increased or decreased over the last month, and indicating if the resident remains baseline. LSW will complete audits on each resident s chart monthly by manually looking at each resident s physician orders to verify each psychotropic drug is on the GDR schedule every month for the next 3 months. Education to nursing staff occurred at the mandatory in-service on 4/3/14. Process will be reviewed at QA meeting on 5/20/14.	

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F 329	Continued From page 46 order to treat his anxiety when he leaves the facility with his family, consultant pharmacist to monitor monthly and advise physician as indicated, continue to educate family Ativan usage, nursing to monitor for anxiety. During interview on 3/14/14, at 4:12 p.m., director of nursing verified physician progress notes lack justification for use of Ativan, Ativan being given per family request and would expect justification for use of Ativan to be in record. Document review of the facility policy and procedure Use of Psychotropic Medications dated 1/7/11, read, "A resident will not receive psychotropic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident ' s behavioral disturbance. A resident will not receive psychotropic medications unless such medication will be given to treat clearly defined target behaviors."	F 329		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced	F 412		4/26/14

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F 412	Continued From page 47 by: Based on observation, interview, and document review, facility failed to provide the necessary care and services for dental concerns for 1 of 3 residents (R25) reviewed for dental services. R25 had loose dentures not identified by the staff and no dental services were provided. Observation and interview with R25 and family (F)-A on 3/11/14 at 10:13 a.m. revealed concerns with loose fitting dentures. Resident indicated since being sick and losing weight her dentures don't fit anymore. F-A agreed and stated, "Mom loads them [denture] up with Polident but she needs them to be realigned. We have no insurance so what are we to do?" The staff indicated no concerns on the annual minimum data set (MDS) dated 11/19/13 and the quarterly MDS 2/18/14, under the dental section which identified broken or loose fitting full or partials dentures. Three comprehensive nursing assessments dated 11/15/13; 1/27/14 and 3/2/14 identify the resident as having upper and lower dentures. All indicate the dentures fit well. Under the section of last known dental exam the nursing assessment dated 1/27/14 indicated resident refused dental consults on 12/16/2010. No further dental consult requests were available. The care plan dated 10/23/13 indicated resident was at risk nutritionally due to weight loss and decline in health status. The plan of care directed staff to assess dentures as needed for adjusting, as with the weight loss she may need frequent adjustments. Staff to notify if dentures become ill	F 412	A Comprehensive dental assessment was completed (3/13/14 & 3/14/15) for R25. On 3/13/14, a Dental appointment was arranged for March 25th for R25. Care plan updated for R25 on 3/26/14. A Dental Care Assessment Policy was created on 4/2/14. Comprehensive Dental assessments and care plan updates for all residents on East unit were completed by 3/26/14. Comprehensive Dental assessments and Care plan updates for all residents on west unit were completed by 4/14/2014. The Dental Care Assessment Policy was revised on 4/2/14. Formal education to all nursing staff at in-service occurred on 4/3/14 regarding the Dental Assessment Policy emphasizing in the event that a resident would be found to have any acute pain, broken/damaged teeth, broken dentures, or any other oral cavity problem, the facility will notify the resident s dentist within a 24 hour period and then implement the dentist s plan of action. In the event of a resident losing his or her dentures, the facility will contact the resident s dentist within 24 hours and be actively looking for the dentures and if the services are available, and the facility will arrange on-site dental services for residents unable to travel. PCC Committee updated comprehensive dental assessment that went live on 4/5/14. Comprehensive Dental assessments will be completed quarterly and dental services will be offered. Care plans will be updated upon the assessment results if needed. An ongoing	

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F 412	Continued From page 48 fitting. Interview with resident on 3/13/14 at 3:10 p.m. indicated she told staff about the loose dentures, but she does not remember who she told. She proceeded to open her mouth and show me how loose they were and then take them out of her mouth. Observed to be very loose and when she opened her mouth (the bottoms) were not fitting to the gum. They have been loose since I lost so much weight. Weight records reveal resident had lost 27 pounds in the last five months. On 3/12/14 at 4:00 p.m. Registered nurse (RN)-C was made aware of the dental concerns and on 3/13/14 made an appointment for the resident to be seen by the dentist for an evaluation. On 3/14/14 at 1:50 p.m. Interview with director of nursing (DON) about dental concerns. The dental policy was requested and the DON indicated they have no policy. The policy and procedure titled, Care of Dentures, dated 2/2/09 directed staff to inspect resident ' s mouth and assess denture fit and report ill-fitting dentures. DON verified the policy was not followed as R25 had been found with loose dentures.	F 412	audit for 3 months will be completed for any resident that would be found to have any acute pain, broken/damaged teeth, broken dentures, or any other oral cavity problem. This audit will ensure that the nursing staff will comply with the Dental Policy and offer to contact dentist within a 24 hour and implement the dentist s plan of action. Process will be reviewed at QA meeting on 5/20/14.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		4/26/14

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F 428	Continued From page 49 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the consultant pharmacist identified lack of clinical signs and symptoms of "anxiety" to warrant the use of an anti-anxiety prn (as needed) medication for 1 of 5 residents (R66) reviewed for unnecessary medications. Findings include: R66 had been admitted on 7/30/12. R66's admission record dated 3/14/14, identified diagnoses that included but not limited to dementia, dysthymic disorder and paralysis agitans. R66's quarterly Minimum Data Set (MDS) dated 2/17/14, identified brief interview of mental status (BIMS) had been five out of fifteen and indicated severe cognitive impairment and no behaviors. Document review of R66's physician orders dated 2/10/14, identified an order for lorazepam (Ativan) 0.5 mg (milligrams) PRN(as needed) give prior to home outings with family, family requests this to be given on a regular basis for dysthymic disorder and review of physician orders dated 12/17/13, 10/14/13, 8/5/13, 6/4/13 and 3/26/13 revealed consultant pharmacy monthly reviews on same physician orders identified no recommendations in regards to Ativan use. Document review of R66's physician nursing	F 428	Pharmacist reviewed medications of resident R66 on 3/20/14. Pharmacist completed GDR request form for Ativan on 3/20/14. GDR request form put into MD rounds book for Nurse Practioner to review on 3/25/14 (MD is currently on vacation). On 3/25/14, NP accepted GDR to .25mg PRN when resident goes on family outings or appointments. Education provided to consultant pharmacy on Ftag 428 on 3/25/14 by DON and Administrator. On going review of psych drugs will continue through psych drug team who meets monthly and maintains schedule of those residents that are due for GDR. Pharmacist will bring any suggestions for GDR s to team and pharmacist as per CMS guidelines. At psychotropic during monitoring meetings, IDT reviews resident s targeted behaviors and evidence based data through staff documentation and Consultant Pharmacist then completes GDR form with information on targeted behaviors exhibited for provider to review. Following psychotropic drug monitoring meetings, Nurse Manager or designee will complete progress note indicating targeted behaviors, stating if targeted behaviors have increased or decreased over the last month, and indicating if the	

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F 428	Continued From page 50 home notes dated 12/17/13, 11/7/13 and 10/14/13 had no documentation regarding Ativan use. Physician nursing home note dated 8/5/13, identified does receive prn Ativan primarily when he goes on outings with family members as they specifically request this medication. R66's care plan print date 3/13/14, identified uses Ativan, an anti-anxiety medication to decrease the feelings of anxiety, behaviors include anxiety related to riding in car with family, has experienced increased anxiety when going out with family, therefore, Ativan is given prior to leaving with family and interventions that included but not limited to administer Ativan to manage anxiety as ordered by physician, this is a prn order to treat his anxiety when he leaves the facility with his family, consultant pharmacist to monitor monthly and advise physician as indicated, continue to educate family Ativan usage, nursing to monitor for anxiety. During interview on 3/14/14, at 4:12 p.m., director of nursing verified physician progress notes lack justification for use of Ativan, Ativan being given per family request and would expect justification for use of Ativan to be in record. During interview on 3/18/14, at 9:43 a.m., facility consultant pharmacist stated I'm not out on visits with family, without a solid reason felt use of drug limited, did not warrant a change, not sure how monitoring parameters could be done in this situation and decision for use based on family concerns. Document review of the facility policy and procedure Use of Psychotropic Medications dated 1/7/11, read, "POLICY: Pharmacy Consultant will	F 428	resident remains baseline. LSW will complete audits on each resident s chart monthly by manually looking at each resident s physician orders to verify each psychotropic drug is on the GDR schedule every month for the next 3 months. Education to nursing staff at mandatory in-service occurred on 4/3/14. Process will be reviewed at QA meeting on 5/20/14.will be reviewed at QA meeting on 5/20/14.	

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F 428	Continued From page 51 monitor drug therapy monthly with recommendations to Primary MD as indicated. A resident will not receive psychotropic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident ' s behavioral disturbance. A resident will not receive psychotropic medications unless such medication will be given to treat clearly defined target behaviors."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		4/26/14

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F 431	Continued From page 52 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide safe and secure storage of controlled medications for 3 of 3 medication carts observed. Findings include: During the tour of the medication carts on east and west units some schedule II narcotics were stored under a single secure lock only and are to be stored in a separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and controlled medications are reconciled accurately. The locked medication carts were stored in the unsecured nursing stations. One cart on the east wing was observed on 3/12/14 at 1:45 p.m. In the narcotic drawer, was a locked narcotic box that contained most of the narcotics. However, Hydrocodone (Vicodin, for pain relief) a schedule II medication was not secured in the narcotics drawer. When interviewed on 3/12/14 at 1:45 p.m. Licensed practical nurse (LPN)-B indicated all narcotics are double locked accept for the ones that don't have to be. She was unsure which ones	F 431	3/12/2014 Controlled Substances (Schedule II Drugs) Policy was updated. 3/12/2014 DON placed all schedule II drugs in a separately locked compartment on all three medication carts ensuring that Scheduled II drugs stored in the medication cart are double locked in secure storage with limited access. 3/12/2014 Pharmacist was updated on Policy update. 3/12/2014 On 3/21/14 A list of narcotics and what level they were on was requested, and the Scheduled Drugs Storage and Organization Document signed by our facility Pharmacist was sent to the requesting surveyor on 3/21/2014. Informal Education completed by DON of policy provided for all license staff by placing an alert on PCC and communicated updated changes via email to all nursing staff. Formal education to all licensed nursing staff provided at in-service on 4/3/14, reviewed update to Controlled Substances Scheduled II Drugs Policy. A bi-weekly audit for 3 months will be completed to ensure that Scheduled II drugs that are stored in the medication cart are double locked in a secure storage with limited access. Process will be reviewed at QA meeting	

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F 431	Continued From page 53 didn't need to be double locked. She indicated all narcotics are counted every shift, there are just some not under double lock and key. She indicated its the same on the west wing. The west wing cart was observed on 3/12/14 at 2:40 p.m. and in the narcotic drawer, was a locked narcotic box that contained most of the narcotics. There were, however, some narcotics not in the locked box and stored in another drawer. Again Hydrocodone (Vicodin, for pain relief) was not in the narcotics drawer. LPN-F, when interviewed on 3/12/14 at 2:45 p.m., indicated narcotics are double locked except for the ones that don't need to be. She verified all narcotics are counted every shift. She could not provide information as to what was double locked and what was single locked. 3/12/14 at 4:00 p.m. registered nurse (RN)-C and RN-D were interviewed and a policy regarding narcotic storage was requested. They verified some narcotics are double locked and some single locked. On 3/13/14 at 8:20 a.m. the director of nursing (DON) presented a new policy indicating all narcotics will now be double locked. She verified all narcotic medications should be under double lock for safety. Rather than trying to differentiate which ones are to be double locked and which ones single locked we will double lock them all. The policy and procedure, titled Controlled Substances (Schedule II Drugs), dated 11/27/13 and revised 3/12/14, read, "Schedule II drugs are kept double locked in the med cart." The DON on 3/13/14 at 8:20 a.m. verified the statement,	F 431	on 5/20/14.	

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F 431	Continued From page 54 "Schedule II drugs are kept double locked in the med cart," was added to the policy 3/12/14. Additional information was requested in a follow up call to the DON on 3/21/14 in regards to the list of narcotics and what level they are, however, that was not provided.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		4/26/14

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F 441	Continued From page 55 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility staff failed to transport soiled linens from the resident ' s room to the soiled utility room for 1 of 1 residents (R66) in a manner to prevent the spread of infection to staff and other residents and the facility failed to provide infection control education to all staff upon hire and annually. This had the potential to affect all residents and staff. Findings include: R66 soiled linens were transported on 3/12/14, at 7:32 a.m., by nursing assistant (NA)-F who had been observed to have the soiled linens and soiled resident gown in bare hand and under her arm touching skin and uniform. On asking NA-F about procedure in handling soiled linens she said that she should have carried soiled linens in a bag. Document review of Sauer Health Care education regarding infection control revealed, nursing in service agenda dated 1/30/14, identified infection control update, nursing in service agenda dated 12/19/13, identified infection control updated policies, all staff meeting agenda dated 10/10/13, identified Flu vaccine, nursing in service agenda	F 441	3/18/14 Disciplinary write up completed for aide that failed to properly handle dirty linens. Linen Handling policy was created on 3/24/2014.This policy provides direction to staff on handling, storing, processing and transporting both clean and soiled linen. All staff education on this new policy was completed on 4/3/14 at all staff inservice. Process will be reviewed at QA meeting on 5/20/14. Our Infection Control Nurse developed an educational packet of information using the CDC and OSHA guidelines on 3/18/14. All staff hired between 3/18/14-4/2/14 had been provided with a face to face education on the following topics: Sauer Health Care Infection Control Policy, Hand Washing: Clean Hands Save Lives Handout (CDC), Bloodborne Pathogens: Safety Training Handout (OSHA), and Preventing The Spread Of Bloodborne Pathogens: Fact and Skill Sheet (OSHA). Staff members that had received this information signed a form indicating that they had an opportunity to review the information. Completed forms with signatures	

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F 441	Continued From page 56 dated 6/20/13, identified Flu vaccines. However, there had been no infection related education for new employees nor done annually. During interview on 3/14/14, at 4:00 p.m., director of nursing stated last infection control education had been done on 11/15/12 and had been for all nursing staff only. Director of nursing stated each department has a checklist they use for newly hired staff, hand washing is covered and a hand washing video is watched. Director of nursing stated there is no documentation of education for infection control annually for all staff or for newly hired staff being done. Director of nursing stated she would expect linens to be bagged up to be carried out of a room and taken to dirty utility room. Document review of the facility policy and procedure Infection Control dated 1/11/2010, read, "Policy Statement: It is the policy of this facility that each resident and staff member be provided with a safe, sanitary and comfortable environment in which to live and work in by adapting processes to prevent development and transmission of disease and infection. Preparation: 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection and exposure control issues, including: a. The facility protocols for isolation (standard and transmission-based) precautions; b. The location of all personal protective gear; c. The location of medical waste disposal containers; d. The facility exposure control plan; and e. The facility protocol for occupational exposures to bloodborne pathogens. 2. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing	F 441	indicating the above will be maintained in the personnel files of the staff members in the HR office. Effective 4/3/14 the new curriculum for infection Control education includes: Infection Control Policy, Hand Washing Policy, Handling Linen Policy, Exposure Policy and an Infection Control power point presentation that explains how to managing infections in residents, types of healthcare- Associated Infections, methods of preventing their spread, how to recognize and report signs and symptoms of infection and prevention of the transmission of multi-drug resistant organisms. A checklist will be maintained upon completion of this orientation which will be placed in the employee file. All staff education on infection control occurred on 4/3/14. On-going education as needed to staff will occur. Administration is currently investigating an online educational tool, through EduCare for new hires and annually for all staff. Administration is discussing having a skills fair this year for all staff to demonstrate competencies in various areas of infection control (ex: hand washing, carrying linens properly). Process will be reviewed at QA meeting on 5/20/14. A linen audit will be completed each shift bi weekly for 2 months ensuring that linens are being carried according to our Linen Handling Policy.	

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 ______	03/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 57 infections in residents, including: a. Types of Healthcare-Associated Infections; b. Methods of preventing their spread; c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug resistant organisms."	F 441		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete performance evaluations every 12 months for 2 of 5 nursing assistants (NA-C, NA-D) whose personnel records were reviewed. Findings include: Review of personnel records on 3/14/14 revealed that nursing assistant (NA)-C was hired in 1979 and had not had a performance evaluation	F 497	3/21/14 Evaluations completed for the 2 Certified Nursing Assistants that were found to be incomplete during survey. DON will ensure that a performance review will be completed for every certified nursing assistant at least once every 12 months. The DON will be responsible to create and update a monthly log that will track when staff are due for an evaluation. The date will be documented on this log when the evaluation has been completed.	4/26/14

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 ______	03/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 58 completed since 7/7/10. Also, NA-D was hired 11/16/12 and had not had a performance evaluation since that date. When interviewed on 3/14/14, at 11:30 a.m. the director of nursing stated that she started to do annual performance evaluations of nursing assistants when she recently started her position at the facility, but had not yet gotten to do an evaluation for NA-C. She went on to explain that NA-D had been on a leave from December 2013 through 2/1/14, and NA-D's annual performance evaluation had been delayed because of that leave.	F 497	This will ensure that all evaluations will be completed in a timely manner. Education occurred with all Nursing assistants on 4/3/14 at the in-service. Process will be reviewed at QA meeting on 5/20/14.	

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

F5102022

PRINTED: 04/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/11/2014**

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sauer Health Care is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type II(222) construction. In 1976, 1982, and 1995 additions were added to the North Wings that were determined to be of Type II (111) 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 II(111). 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/11/2014**

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

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K 000	Continued From page 2 the residents room. The facility has a capacity of 71 beds and had a census of 64 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide the proper corridor separation from use areas. This deficient practice could affect the exiting of all residents and staff within the smoke compartment. NFPA 101 section 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	A smoke detector was installed outside in the area by the east med room where the area is used for storage on 3/25/14. Education to all staff on this update was completed on 4/3/14.	4/26/14

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	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/11/2014**

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

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K 017	Continued From page 3 Findings include: On facility tour between 09:30 AM and 12:30 PM on 03/11/2014, it was observed that the Wheelchair/Lift storage area, located by the East Med. Storage Room is an area open to the corridor and not covered by automatic smoke detection. This does not meet the exceptions to NFPA 101, 2000 Ed., Section 19.3.6.1. This deficient practice was verified Environmental Service Director (DM),	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 018	A positive latching device was installed on	4/26/14

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

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K 018	Continued From page 4 did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:30 AM and 12:30 PM on 03/11/2014, it was observed that it was observed that the corridor door to the 1st floor Administrator Office by the front entrance did not have latching hardware suitable for keeping the door closed. The door required a key to latch the door. This deficient practice was verified Environmental Service Director (DM),	K 018	the door entering the Administrator□s office from the corridor on 3/19/14. Education to all staff on this update was completed on 4/3/14.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This	K 029	The penetration in the corridor wall between by the east medications room was sealed with an approved fire resistive material on 4/3/14. Education to all staff	4/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/11/2014**

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

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K 029	Continued From page 5 deficient practice could affect all residents and staff within the smoke compartment. Findings include: On facility tour between 09:30 AM and 12:30 PM on 03/11/2014, it was observed that there was a penetration completely around a sprinkler pipe in the corridor wall of the East Med/Storage Room. This deficient practice was verified Environmental Service Director (DM),	K 029	on this update was completed on 4/3/14.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to develop a separate written policy containing procedures to be followed in the event the automatic fire sprinkler system is out-of-service for more than four hours in a 24-hour period. This deficient practice could affect all residents, staff and visitors in the event of a fire. 200 LSC Sec 9.7.6.1 Findings include: On facility tour between 09:30 AM and 12:30 PM on 03/11/2014, it was discovered during policy review and interview with the Environmental	K 154	The policy for Fire Alarm Outage and Fire Sprinkler Outage was separated into two different policies on 3/31/2014. Education to all staff on this update was completed on 4/3/14.	4/26/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/11/2014**

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

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K 154	Continued From page 6 Service Director (DM), that the facility has not developed a separate policy and procedures for an out-of-service fire sprinkler system.	K 154		

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245102	**SAUER HEALTH CARE**	*K4 **03/11/2014**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A] A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ] 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ] 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ] 7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [ ]	A2 [X]	A3 [ ]	A4 [ ]	A5 [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [X]

K180:

A. [ ]	B. [X]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

NPI # 1689757692

S5102023

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: sblair@sauerhealthcare.org

National Provider Identifier (NPI) Number: 1689757692

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: SAUER HEALTH CARE City: WINONA

Name of Legal Entity Operating Provider: SAUER HEALTH CARE

Name and Address of Governing Board President:

Name: TERRY SONNENFELD

Address: 902 - 2ND ST E STE 150

City/State/Zip: WINONA, MN 55987

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: ____________ City: ____________

Name of Legal Entity Operating Provider: ____________

Name and Address of Governing Board President:

Name: ____________

Address: ____________

City/State/Zip: ____________

SIGNATURE

Completed by: Da Blair

Title: Administrator

Date: 3/11/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245102	SAUER HEALTH CARE

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

B					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

	Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	Team Leader 15425	03-10-2014	03-17-2014	1.00	1.00	27.50	2.00	7.00	7.25
2.	19200	03-10-2014	03-14-2014	0.00	1.00	18.75	5.00	12.00	21.25
3.	20810	03-10-2014	03-14-2014	0.25	1.00	34.25	2.50	6.00	9.25
4.	32980	03-10-2014	03-14-2014	0.25	1.00	28.50	3.00	7.50	12.75
5.									
6.									
7.									
8.									
9.									
10.									

Total Supervisory Review Hours 20.50

Total Clerical/Data Entry Hours... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y

FORM HCFA-670 (12-91)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
245102	SAUER HEALTH CARE

Type of Survey (select all that apply):

H	I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

	Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	Team Leader 12424	03-11-2014	03-11-2014	1.00	0.00	3.00	0.00	4.00	2.00
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours... .25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245102	SAUER HEALTH CARE

Type of Survey (select all that apply):

A					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader 1. 15425	03-12-2014	03-14-2014	0.50	0.00	9.00	0.00	3.00	0.50
2. 19200	03-12-2014	03-17-2014	0.00	0.00	17.25	0.00	2.50	0.00
3. 20810	03-12-2014	03-14-2014	0.00	0.00	3.00	0.00	1.50	0.00
4. 32980	03-12-2014	03-14-2014	0.00	0.00	1.00	0.00	3.00	0.00
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours .... 0.00 .25

Total Clerical/Data Entry Hours... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **03/10/14** To F2: 03/17/2014	Extended Survey Date Format: mm/dd/yy From F3: **03/13/14** To F4: **03/17/14**	
Name of Facility: **SAUER HEALTH CARE**	Provider Number: **245102**	Fiscal Year ending:
Address: **1635 WEST SERVICE DRIVE, WINONA, WINONA, MN 55987**		
Telephone Number: F6	State/County Code: **MN / WINONA**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0** Huntington's Disease F21 **0** Other Spec Rehab. F23 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0** Ventilator/Respiratory Care F22 **0**	
Does the facility currently have an organized resident group? F24	**Yes**	
Does the facility currently have an organized group of family members of residents? F25	**No**	
Does the facility conduct experimental research? F26	**No**	

Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **NA**	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

	Tag #	A: Services Provided 1	2	3	B: Full-Time Staff (hours)	C: Part-Time Staff (hours)	D: Contract (hours)
Administration	F33				**232**	**0**	**0**
Physician Services	F34	**No**	**No**	**Yes**			
Medical Director	F35				**0**	**0**	**1**
Other Physician	F36				**0**	**0**	**0**
Physician Extender	F37	**No**	**No**	**No**	**0**	**0**	**0**
Nursing Services Yes	F38	**No**	**No**	**No**			
RN Director of Nursing	F39				**80**	**0**	**0**
Nurses with Admin Duties	F40				**166**	**0**	**0**
Registered Nurses	F41				**92**	**195**	**0**
Licensed Practical/ Vocational Nurses	F42				**391**	**287**	**0**
Certified Nurse Aides	F43				**1228**	**1059**	**0**
Nurse Aides in Training	F44				**0**	**0**	**0**

Medication	F45				0	184	0
Pharmacists	F46	Yes	No	No	0	0	4
Dietary Services	F47	Yes	No	No			
Dietitian	F48				0	0	6
Food Service Workers	F49				72	525	0
Therapeutic Services	F50						
Occupational Therapist	F51	Yes	Yes	No	0	0	35
Occupational Therapy Assistant	F52				0	0	58
Occupational Therapy Aides	F53				0	0	0
Physical Therapist	F54	Yes	Yes	No	0	0	31
Physical Therapy Assist	F55				0	0	74
Physical Therapy Aides	F56				0	0	0
Speech/Language	F57	Yes	Yes	No	0	0	2
Therapeutic Recreation Spec.	F58	Yes	No	No	160	0	0
Qualified Activities Prof.	F59	No	No	No	0	0	0
Other Activities Staff	F60	Yes	No	No	0	61	0
Qualified Social Workers	F61	Yes	No	No	80	0	0
Other Social Services Staff	F62	Yes	No	No	0	19	0
Dentists	F63	No	No	No	0	0	0
Podiatrists	F64	Yes	No	No	0	0	0
Mental Health Services	F65	No	No	No	0	0	0
Vocational Services	F66	No	No	No			
Clinical Laboratory Services	F67	No	No	No			
Diagnostic X-ray Services	F68	Yes	No	No			
Administration Storage of Blood	F69	No	No	No			

Housekeeping Services	F70	Yes No No	**244**	**181**	**0**
Other	F71		**160**	**79**	**0**
Name of Person Completing Form: **Sara Blair, Administrator**					Date: **03/21/14**

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Information on this website is available in alternative formats upon request.

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

SAUER HEALTH CARE				
Provider No. **245102**	Medicare F75 **6**	Medicaid F76 **37**	Other F77 **21**	Total Residents F78 **64**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **0**	F80 **35**	F81 **29**
Dressing	F82 **4**	F83 **46**	F84 **14**
Transferring	F85 **9**	F86 **44**	F87 **11**
Toilet Use	F88 **3**	F89 **52**	F90 **9**
Eating	F91 **36**	F92 **20**	F93 **8**

A. Bowel/Bladder Status

F94 **3** With indwelling or external catheter.

F95 Of total number of residents with catheters, **2** were present on admission.

F96 **54** Occasionally or frequently incontinent of bladder.

F97 **17** Occasionally or frequently incontinent of bowel.

F98 **21** On individually written bladder training program.

B. Mobility

F100 **1** Bedfast all or most of time..

F101 **57** In chair all or most of time.

F102 **10** Independently ambulatory.

F103 **27** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F99 **19** On individually written bowel training program.	F105 Of total number of residents with restrained, **0** were admitted with orders for restraints. F106 **12** With contractures. F107 Of total number of residents with contractures, **9** had contractures on admission.

C. Mental Status	**D. Skin Integrity**
F108 **2** With mental retardation.	F115 **4** With pressure sores (exclude stage I).
F109 **22** With documentation signs and symptoms of depression.	F116 **1** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?
F110 **20** With documentation psychiatric diagnosis (excluding dementias and depression).	F117 **32** Receiving preventive skin care.
F111 **34** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.	F118 **3** With rashes.
F112 **27** With behavioral symptoms.	
F113 **27** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.	
F114 **0** Receiving health rehabilitative services for MI/MR.	

E. Special Care	
F119 **6** Receiving hospice care benefit.	F127 **1** Receiving suction.
F120 **0** Receiving radiation therapy.	F128 **12** Receiving injections (exclude vitamin B12 injections)
F121 **0** Receiving chemotherapy.	F129 **2** Receiving tube feedings.
F122 **0** Receiving dialysis.	F130 **21** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **12** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **12** Receiving respiratory treatment.	F132 **8** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	

F126 **2** Receiving ostomy care.	

F. Medication	G. Other
F133 **43** Receiving any psychoactive medication.	F140 **2** With unplanned significant weight loss/gain.
F134 **10** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **15** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **38** Receiving antidepressant medications.	F143 **64** With advance directives.
F137 **2** Receiving hypnotic medication.	F144 **61** Received influenza immunization.
F138 **4** Receiving antibiotics.	F145 **61** Received pneumococcal vaccine.
F139 **10** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Sara Blair	**Administrator**	**03/18/2014**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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- Facilities & Professions
- Health Care & Coverage
- Injury, Violence & Safety
- Life Stages & Populations

Olson, Cynthia (MDH)

From: oracle@health.state.mn.us
Sent: Wednesday, May 21, 2014 9:35 PM
To: MONICA.LARSON@STATE.MN.US LISA.SHERRY@STATE.MN.US CYNTHIA.OLSON@STATE.MN.US SHARON.PIKULA@STATE.MN.US
Subject: SAUER HEALTH CARE - Move LNC Survey to Web

The Facility SAUER HEALTH CARE (HFID - 00705) Survey Project 'S5102023' and Aspen Event ID 'OANL11' is successfully moved to Web.

Transaction Report

For: SAUER HEALTH CARE - 00705

Certification ID: OANL **Provider #:**245102 **Survey Date:** 03/17/2014

Printed: 05/28/2014

Transaction Number: 240004277944 **On:** 05/27/2014 **By:** HOFFMAN, CHERYL
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004277917 **On:** 05/27/2014 **By:** HOFFMAN, CHERYL
Tran Type: 03 - ADD **Status:** -1 - Failed Prevalidation in ASPEN

Message Detail:
C381-562.PARTY_DT_1: PARTY DATE 1 (03/10/2014) MUST BE EQUAL TO OR LATER THAN COMPLAINT SURVEY DATE (#10) (03/17/2014).

Transaction Number: 240004273671 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273669 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273667 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273665 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273663 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273661 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273659 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273657 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273655 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273653 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273651 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273649 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273647 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273645 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273643 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273641 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273639 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273637 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273635 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273633 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273631 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273629 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273627 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE
Message Detail:

Transaction Number: 240004273625 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273623 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273621 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273619 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273617 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273615 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273613 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273611 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273609 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273607 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273605 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273603 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273601 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273599 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273597 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273443 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273442 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273441 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273440 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273439 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273438 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273437 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273436 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273435 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273434 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273433 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273432 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273431 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273430 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273429 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273428 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273427 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273426 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004273425 **On:** 05/22/2014 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Transaction Number: 240004269717 **On:** 05/21/2014 **By:** OLSON, CYNTHIA
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail: