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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WHMT

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: **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 **4/4/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **71** (L18)
13.Total Certified Beds **71** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, Unit Supervisor 05/6/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 05/28/2019 (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

Electronically delivered
April 18, 2019

Administrator
Sauer Health Care
1635 West Service Drive
Winona, MN 55987

RE: Project Number S5102029

Dear Administrator:

On April 4, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is May 14, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 July 4, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by October 4, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING _____ B. WING _____	C 04/04/2019

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
E 000	Initial Comments A survey for CMS Emergency Preparedness Requirements was conducted on 4/2/2019, through 4/4/2019, during a recertification survey. Sauer Health Care was found NOT IN COMPLIANCE with the CMS Appendix Z Emergency Preparedness Requirements.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039		5/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2019

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E 039	Continued From page 1 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure they conducted exercises to test their emergency plan at least annually, including participation in a full scale and table top exercises. This had the potential to affect 59 residents currently residing in the facility, as well as staff and visitors. The findings include:	E 039	In response to the above stated citation Sauer Health Care has taken the following action: " The Facility Emergency Preparedness Binder was reviewed and updated to ensure that completion and review of documentation are included in the plan to meet this requirement. " The Facility has signed on as an active member of the Southeast	

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E 039	Continued From page 2 In review of the facility's Emergency Preparedness Plan the facility failed to document the staff who attended their tabletop exercise. The tabletop exercise further lacked a documented scenario, synopsis, and analysis. The facility further failed to identify participation in a full scale exercise. During interview on 4/4/19 at 12:15 p.m., the administrator verified the above. The administrator stated the facility had participated in a Fire Drill and a Missing Resident exercise, in the last year, but had lacked the above documentation.	E 039	Minnesota Disaster Health Coalition and will participate in and document on a full-scale exercise annually. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. The facility ascertained a form from the SE MN Disease Health Coalition to document and analyze the table top exercises. The next scheduled exercise is May 15th. A fire drill was done on 4/30/19 on the night shift, these drills are done one time per month, with each month being on a different shift covering all 3 shifts in a quarter. The drills are documented on a form that evaluates the drill and determines areas of improvement needed. Elopement drills are done 2x a year and a new form was created to address evaluation of the drill and determine areas of improvement needed. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby	E 041		5/14/19

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E 041	Continued From page 3	E 041		

power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)
(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it

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E 041	Continued From page 4 evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.	E 041		

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E 041	Continued From page 5 (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the State Fire Marshal identified the facility failed to comply with Life Safety Code (3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3) Standard for Emergency and Standby Power Systems. This deficient practice had the potential to affect the safety of all 59 residents, staff and visitors in the facility. Findings Include: The State Fire Marshall conducted a facility tour on 4/3/2019, between 9:00 a.m. and 1:00 p.m.. It was observed during the walk-through inspection of the facility that their emergency generator did not have an externally mounted E-stop (emergency stop) button. This deficient practice was confirmed by the Maintenance Director (MD) at the time of discovery.	E 041	In response to the above stated citation Sauer Health Care has taken the following action: " An externally mounted E-Stop (Emergency Stop) button was installed on 04/15/2019. " The Facility Emergency Preparedness Binder was reviewed and updated. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	
F 000	INITIAL COMMENTS On 4/2/2019, through 4/4/2019, a standard recertification survey was completed at your facility by the Minnesota Department of Health. Sauer Health Care was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term	F 000		

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F 000	Continued From page 6 Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		5/14/19

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F 880	Continued From page 7	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

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 _____	C 04/04/2019

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 880	Continued From page 8 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate disinfection of glucometer equipment (the machine that detects the level of sugar from the sample of blood) for 4 of 4 nursing staff observed doing blood sugar monitoring. This had the potential to affect all 13 residents in the facility who have blood sugar checks. Findings include: During an observation on 4/2/19, at 11:43 a.m. licensed practical nurse (LPN)-A received a blood sample and tested it with a glucometer. According to LPN-A, the facility was sharing glucometers between multiple residents. Following testing of the blood sample, LPN-A returned to the nurses' station and took a cleansing wipe labeled Microkill Germicidal Alcohol Wipes and wiped off the glucometer for about 30 to 40 seconds and then placed the wet glucometer in a drawer of the medication cart, shut the drawer and left the room. During an observation and interview on 4/3/19, at 4:49 p.m. trained medication aide (TMA)-A received a blood sample and tested it using a shared glucometer. After this, TMA-A returned to the nurses' station, set the glucometer on a towel on the medication cart and took a cleansing wipe, labeled as a bleach wipe, from the cart and cleaned the glucometer then placed it back on the	F 880	In response to the above stated citation Sauer Health Care has taken the following action: " A Manufactures Instruction Manual for the glucometer was placed in each medication cart for reference. " Policy titled, Blood Glucose Monitoring, Obtaining a Finger Stick Glucose Level was modified to include directions for staff to see Cleaning and Disinfecting of Glucometer policy for guidance on disinfection procedures for glucometers. " Policy titled, Cleaning and Disinfecting of Glucometer was created to provide specific guidance to staff on disinfection procedures for glucometers. " Communication of the above plan will be provided to Licensed Nursing Staff and Trained Non-Licensed Nursing Staff with confirmation of learning to be complete on or before May 14, 2019. Facility DON will conduct audits of proper cleaning techniques weekly for 2 months covering all shifts where blood sugar monitoring occurs and document these audits, addressing any non compliance issues with the appropriate staff at the time. Audit/monitoring will be completed on 7/14/19.	

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F 880	Continued From page 9 cart. TMA-A stated they were supposed to use bleach wipes not alcohol wipes to clean the glucometers, but was unsure of the bacterial/viral kill time when asked. TMA-A reviewed the label of the bleach wipes used and stated they required 30 second of cleaning except when in the presence of clostridrium dificile (C.dif) infections. This would require three minutes of cleaning. TMA-A stated she estimated the time she spent cleaning the glucometer was about 10 seconds and confirmed this was not an adequate length of time for disinfection. During an observation on 4/4/19, at 7:11 a.m. LPN-B gathered a blood sample for testing using a shared glucometer. Following this, LPN-B returned to the medication cart and obtained a bleach wipe. LPN-B wiped the glucometer for about 10 seconds and placed the glucometer on top of the cart, performed hand hygiene and then went on to prepare medications for a resident. According to an interview on 4/4/19, at 8:26 a.m. LPN-B described how she cleaned glucometers, "Well, I use these bleach wipes and then let it sit. It has to sit for, like 10 minutes before I can use it again." LPN-B was not able to state the bacterial/viral kill time but after reading the bleach wipe label said the wipe would kill C.dif spores in three minutes. During an observation and interview on 4/4/19, at 7:20 a.m. TMA-B gathered a blood sample with the shared glucometer. Afterwards, TMA-B returned to the medication cart, removed a bleach wipe from the cart and wiped the glucometer for about 10 seconds. TMA-B was unsure of the bacterial/viral kill time and initially said one minute. After referring to the label	F 880	Compliance for adherence to this plan will be the responsibility of the Director of Nursing with overall compliance being the responsibility of the Facility Administrator.	

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F 880	Continued From page 10	F 880		

TMA-B said, "Oh, it says here, three minutes. So I can't use it again for three to five minutes." TMA-B stated the facility had several types of wipes available, but they were supposed to use the bleach wipes. TMA-B left the glucometer on top of the cart and left the area.

During an interview on 4/4/19, at 11:45 p.m. the director of nursing (DON) stated it was the facility policy to follow manufacturer instructions for cleaning glucometers. DON stated an expectation for nursing staff to use bleach wipes to clean the glucometers between every use. DON referred to the bleach wipe label and stated a minimal contact time of 30 seconds was required to effectively kill bacteria and viruses with the exception of C. dif which required three minutes.

A copy of the glucometers' manufactures instructions for sanitization was requested, but the information provided merely indicated the glucometer should be cleaned and disinfected between patients and listed the approved products for cleaning. The instructions did not include information related to bacterial/viral kill time, how to clean or wipe or how to store the glucometer.

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	245102	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2019**

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	INITIAL COMMENTS	K 000		

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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

By email to:
fm.hc.Inspections@state.mn.us

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2019

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sauer Health Care is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type III(211) construction. In 1972, addition was constructed to the South Wing that was determined to be of Type III(211)construction. In 1976, 1982, and 1995 additions were added to the North Wings that were determined to be of Type III (211) construction. Because the original building and the 4 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III(211). The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 71 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.10.1) This deficient practice could affect the safety of all (59) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/02/2019, observations and staff interview revealed the following: During the walk-through inspection of the facility observed the Exit light in the Physical Therapy Room was not illuminated This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 293	In response to the above stated citation Sauer Health Care has taken the following action: " The Exit Light in the Physical Therapy Room was replaced on 04/15/2019. " The Maintenance Department will be conducting monthly rounds to ensure all Exit Signage lights are illuminated. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	5/14/19
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		5/14/19

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K 355	Continued From page 3 Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.12, NFPA 10) This deficient practice could affect the safety of all (59) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/02/2019, observations and staff interview revealed the following: During the walk-through inspection of the facility observed obstructed access to fire extinguishers in the following locations: 1) Chapel area - hidden and obstructed by furniture 2) East Nurses Station - hidden and obstructed by Nurses Charting Cart This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	In response to the above stated citation Sauer Health Care has taken the following action: " The Portable Fire Extinguisher in the East Nurses Station was moved to a different location on 04/10/2019 where obstruction would be avoided. " Furniture in the Chapel Area was immediately moved to correct obstruction. " Staff have been instructed through Stand-Up Meeting Communications on 04/10/2019 that fire extinguishers are not to be blocked at any time. " This information has also been added to the new employee orientation. " The Maintenance Department will be conducting monthly rounds to ensure all Portable Fire Extinguishers are free from obstruction. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		5/14/19

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K 511	Continued From page 4 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.5.1.1, 9.1.1, 9.1.2, NFPA 70) This deficient practice could affect the safety of all (59) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/02/2019, observations and staff interview revealed the following: During the walk-through inspection of the facility observed unsecured electrical panels in the following locations: 1) Resident accessible corridor by the Chapel (Panel BL3) 2) Resident accessible corridor - Dining Rm corridor This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	In response to the above stated citation Sauer Health Care has taken the following action: " All electrical panels in resident accessible areas have been locked. " Signage has been placed on the panel doors indicating Panel Must Be Locked. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	

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K 918	Continued From page 5	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		5/14/19

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K 918	Continued From page 6 The facility failed to comply with Life Safety Code (NFPA 110, 5.6.5.6, 5.6.5.6.1, NFPA 70) This deficient practice could affect the safety of all (59) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/02/2019, observations and staff interview revealed the following: During the walk-through inspection of the facility observed the emergency generator did not have an remote or externally mounted E-stop (emergency stop) button This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	In response to the above stated citation Sauer Health Care has taken the following action: " An externally mounted E-Stop (Emergency Stop) button was installed on 04/15/2019. " Communication of the above plan will be provided to all staff with confirmation of learning to be complete on or before May 14, 2019. Compliance for adherence to this plan will be the responsibility of the Environmental Services Director with overall compliance being the responsibility of the Facility Administrator.	

Electronically delivered
April 18, 2019

Administrator
Sauer Health Care
1635 West Service Drive
Winona, MN 55987

Re: State Nursing Home Licensing Orders - Project Number S5102029

Dear Administrator:

The above facility was surveyed on April 2, 2019 through April 4, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

Please feel free to call me with any questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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	00705	A. BUILDING: _____ B. WING _____	C 04/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 04/02/19 - 04/04/19, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		5/14/19

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21390	Continued From page 3 Based on observation, interview and document review the facility failed to ensure adequate disinfection of glucometer equipment (the machine that detects the level of sugar from the sample of blood) for 4 of 4 nursing staff observed doing blood sugar monitoring. This had the potential to affect all 13 residents in the facility who have blood sugar checks. Findings include: During an observation on 4/2/19, at 11:43 a.m. licensed practical nurse (LPN)-A received a blood sample and tested it with a glucometer. According to LPN-A, the facility was sharing glucometers between multiple residents. Following testing of the blood sample, LPN-A returned to the nurses' station and took a cleansing wipe labeled Microkill Germicidal Alcohol Wipes and wiped off the glucometer for about 30 to 40 seconds and then placed the wet glucometer in a drawer of the medication cart, shut the drawer and left the room. During an observation and interview on 4/3/19, at 4:49 p.m. trained medication aide (TMA)-A received a blood sample and tested it using a shared glucometer. After this, TMA-A returned to the nurses' station, set the glucometer on a towel on the medication cart and took a cleansing wipe, labeled as a bleach wipe, from the cart and cleaned the glucometer then placed it back on the cart. TMA-A stated they were supposed to use bleach wipes not alcohol wipes to clean the glucometers, but was unsure of the bacterial/viral kill time when asked. TMA-A reviewed the label of the bleach wipes used and stated they required 30 second of cleaning except when in the presence of clostridrium dificile (C.dif) infections. This would require three minutes of cleaning.	21390	"Corrected"	

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21390	Continued From page 4 TMA-A stated she estimated the time she spent cleaning the glucometer was about 10 seconds and confirmed this was not an adequate length of time for disinfection. During an observation on 4/4/19, at 7:11 a.m. LPN-B gathered a blood sample for testing using a shared glucometer. Following this, LPN-B returned to the medication cart and obtained a bleach wipe. LPN-B wiped the glucometer for about 10 seconds and placed the glucometer on top of the cart, performed hand hygiene and then went on to prepare medications for a resident. According to an interview on 4/4/19, at 8:26 a.m. LPN-B described how she cleaned glucometers, "Well, I use these bleach wipes and then let it sit. It has to sit for, like 10 minutes before I can use it again." LPN-B was not able to state the bacterial/viral kill time but after reading the bleach wipe label said the wipe would kill C.dif spores in three minutes. During an observation and interview on 4/4/19, at 7:20 a.m. TMA-B gathered a blood sample with the shared glucometer. Afterwards, TMA-B returned to the medication cart, removed a bleach wipe from the cart and wiped the glucometer for about 10 seconds. TMA-B was unsure of the bacterial/viral kill time and initially said one minute. After referring to the label TMA-B said, "Oh, it says here, three minutes. So I can't use it again for three to five minutes." TMA-B stated the facility had several types of wipes available, but they were supposed to use the bleach wipes. TMA-B left the glucometer on top of the cart and left the area. During an interview on 4/4/19, at 11:45 p.m. the director of nursing (DON) stated it was the facility	21390		

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21390	Continued From page 5	21390		

policy to follow manufacturer instructions for cleaning glucometers. DON stated an expectation for nursing staff to use bleach wipes to clean the glucometers between every use. DON referred to the bleach wipe label and stated a minimal contact time of 30 seconds was required to effectively kill bacteria and viruses with the exception of C. dif which required three minutes.

A copy of the glucometers' manufactures instructions for sanitization was requested, but the information provided merely indicated the glucometer should be cleaned and disinfected between patients and listed the approved products for cleaning. The instructions did not include information related to bacterial/viral kill time, how to clean or wipe or how to store the glucometer.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could write a clear procedure for cleaning and disinfecting shared glucometers and assure that all nursing staff receive training on the procedure, correct products to use for disinfection until such time as the facility chooses to provide individual glucometers for diabetic residents. Audits monitoring the correct techniques for appropriate disinfection could be initiated.

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