

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 17, 2021

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

RE: CCN: 245102

Cycle Start Date: January 29, 2021

#### Dear Administrator:

On January 29, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an onsite 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:

Sauer Health Care February 17, 2021 Page 2

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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, RN, Unit Supervisor Rochester District Office 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

Office: (507) 206-2727 Mobile: (507) 461-9125

#### 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 April 29, 2021 (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).

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In addition, if substantial compliance with the regulations is not verified by July 29, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 03/08/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	()	X3) DATE SURVEY COMPLETED
		245102	B. WING			C <b>01/29/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 1635 WEST SERVICE DRIVE WINONA, MN 55987	CODE	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B	
E 000	was conducted on at your facility by th Health to determine	sed Infection Control survey 1/27/21, 1/28/21 and 1/29/21, e Minnesota Department of e compliance with Emergency	E 0	00		
F 000	facility was in full co Because you are en signature is not req page of the CMS-2 correction is require	nrolled in ePOC, your uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.	F 0	00		
	survey was comple complaint investiga Infection Control su 1/27/21, 1/28/21 an Department of Hea with §483.80 Infect was found to be in	11 and 1/29/21, an abbreviated ted at your facility to conduct tions. A COVID-19 Focused arvey was also conducted on ad 1/29/21, by the Minnesota Ith to determine compliance ion Control. Sauer Health Care compliance with 42 CFR Part for Long Term Care Facilities ction Control.				
		plaint was found to be 02030C and H5102029C with				
	H5102027C and H5 F755.	5102028C deficiency issued at				
	The following compunsubstantiated: H5102031C.	plaint was found to be				
	signature is not req	ed in ePOC and therefore a uired at the bottom of the first				
ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

**Electronically Signed** 

02/25/2021

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	NG	COM	E SURVEY IPLETED
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	correction is require acknowledge receip	567 form. Although no plan of ed, it is required that the facility of the electronic documents. cocedures/Pharmacist/Records	F 0			3/31/21
	§483.45 Pharmacy The facility must prodrugs and biologica them under an agre §483.70(g). The fa personnel to admin					
	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to meet	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.				
		Consultation. The facility ain the services of a licensed				
	§483.45(b)(1) Provi aspects of the provi the facility.	ides consultation on all ision of pharmacy services in				
		blishes a system of records of tion of all controlled drugs in enable an accurate				
	order and that an a is maintained and p	rmines that drug records are in ccount of all controlled drugs periodically reconciled. NT is not met as evidenced				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
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				1635 WEST SERVICE DRIVE		
SAUER I	HEALTH CARE			WINONA, MN 55987		
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F 755	by: Based on interview facility failed to havidentify medication when medications orders for 2 of 3 remedication administriction administricti	v and document review the e medications available, errors and notify physician were not administered per sidents (R1, R7) reviewed for stration.  ication orders dated 10/14/20 in (used to treat nerve and ling fibromyalgia) capsule may by mouth three times a neuropathy (is when multiple become damaged) due to other area on 11/16/20 indicated abalin medication on Sunday red. It included that she was go that it was ordered on ated her feet were burning. To grievance indicated that the told her that staff did not ation when they should have out. Follow up included that ing provided coaching and the medication to staff.  Ininistration record for depregabalin was not given to (at bedtime) November 16th moen 16th noon. On November in emedication was not available, er notation for the two doses	F 75	In response to the above stated Sauer Health Care took immedia actions:  " Initial verbal education provid Manager re: concerns related to medication errors.  " Initial investigation by DON i and R7 to determine root cause, any and address concerns related medication errors.  " Individual counseling done weregularly scheduled AM and PM LPNs  Additional actions taken by Sauer Care since 1/29/2021  " Notification provided to Prove R1 and R7 related to missed mee Mandatory Licensed Staff/TN in-service on 2/16/2021. Education provided to staff regarding Medication Events  " Created Licensed Staff End document that is to be filled out the shift related to medication administration, by Don will evaluate its effectivened data and determine new process forward.  " Update of the following policed in the shift related to medication administration, of Guidelines Policy  Medication Event Policy	ded to RN  Into R1 effects if id to  with shift  If Health ider for dications.  If A concation es and cof Shift for each istration, cerns.  If See is seen eral of the concation of the concation is seen eral of the concation of	
	November indicate November 15th HS morning and Nover 15th according to the record (MAR) the nothern was no furth	d pregabalin was not given (at bedtime) November 16th mber 16th noon. On November ne medication administration nedication was not available. er notation for the two doses		forward.  " Update of the following polic 1. Medication Administration, G Guidelines Policy 2. Medication Event Policy 3. Physician □s Order Transcrip Policy	ies General otion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` '	SURVEY PLETED	
			A. BUILDI	ING	<del></del>		,	
		245102	B. WING				29/2021	
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					5 WEST SERVICE DRIVE			
SAUER I	HEALTH CARE				NONA, MN 55987			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RIATE	COMPLETION DATE	
F 755	Continued From pa	age 3	F 7	'55				
	R1 face sheet inclu	uded diagnoses of malignant		!	5. Disposal of Controlled and			
	neoplasm of anus,	fibromyalgia, and chronic pain			Non-Controlled Medications Policy			
		ropathy due to other toxic			<ol><li>Emergency Medication Kit (E-k</li></ol>	(it) Use		
	agents, restless leg	g syndrome.		(	of and Replacement Policy			
	D. 1. 1	0 ((1100)		'	" EKIT binders will be updated w	ith		
		Set (MDS) assessment dated		(	current medication content " Medication Event discussion/re			
		l almost constant pain 10. MDS included R1 has			added to new QAPI format for Marc			
		ded, and non-medication			meeting	J11		
	interventions for pa			;	" DON completed random samp	lina		
	micor vormiono noi po	managemena			review of 10 (25%) resident medica			
	R1 care plan includ	ded R1 has pain related to			administration records over the last			
		and diagnoses of irritable bowel		ı	months. No adverse effects noted.			
		legs, gastroesophageal reflux		'	" DON or designee will complete			
		gia, and polyneuropathy. Goals			audits of medication administration			
		rbalize adequate relief of pain			residents x 2 weeks, then weekly x			
		ith incompletely relieved pain			weeks, then monthly x 6 months to			
		e. R1 interventions included iveness of pain interventions			compliance and address any violati the plan.	on oi		
		npliance, alleviating of			และ pian. "     Create Medication Re-Order Po	olicy		
		schedules, and resident			" Health Care Academy courses			
		sults, impact on functional			assigned to Licensed staff and TM			
		on cognition; R1 is able to call			Medication Administration assigned			
		n in pain, reposition self, ask			licensed staff to be completed by 3			
	for medication, tell	how much pain is experienced			Medication Assistance for the Medi	cation		
		s or alleviates pain; R1 pain is			Aides assigned to TMA staff to be			
		by rest, repositioning,		(	completed by 3/31/2021.			
		d to relieve pain, swelling			" In March 2021, Licensed Pharr	nacist		
		d joint stiffness caused by ine patches, distractions, and			Consultant will resume in person, pre-COVID audits and med pass			
	oral medication.	line patches, distractions, and			observations.			
	oral illeulcation.				" Education of this will be provide	ed to		
	During an interview	v on 1/28/21 at 10:45 a.m.,			appropriate staff with confirmation			
		e is a process to follow when			learning to be complete on or befor			
		w or not available. Nursing are			March 31, 2021			
		running out and or call			•			
		edications are not delivered on		(	Compliance for adherence to this p	lan will		
		a medication is not available,			be the responsibility of the Director	of		
	the nurse should de	ocument and make a			Nursing with overall compliance be	ing the		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COM	E SURVEY PLETED
		245102	B. WING			1	C <b>29/2021</b>
	PROVIDER OR SUPPLIER			16	REET ADDRESS, CITY, STATE, ZIP CODE 35 WEST SERVICE DRIVE INONA, MN 55987	, , , , , ,	
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F 755	medication (error)  During an interview stated she was nowas not ordered u R1 on 11/16/21. Donly medication massumed the othe stated staff felt the status with the mismedication events missed doses. Doin rounds book registed the nurses if medication not a education with state event. DON stated is no documentation available for the dostated [name of arpharmacy for ememain pharmacy] undue to the pandem 6:30 p.m. DON stated in the pandem 6:30 p.m. DON stated on the units know why staff did document regardin document regarding an interview registered nurse (I had printed script out and placed it on the panded it of	event report.  If you on 1/28/21 at 1:13 p.m., DON to aware that the medication intil the grievance was filed by ON stated pregabalin was the issed. DON stated staff in staff had ordered it. DON are was no change in pain issed doses. DON stated a should have been filed for the inverse of the informing the resident wailable. DON stated she did if on ordering following the informing the resident vailable. DON stated she did if on ordering following the informing the medication not obses missed on 11/16/21. DON nother pharmacy] is the backup regencies. DON stated [name of seed to deliver twice daily but not only delivers once daily at atted there is a procedure for ons after hours and weekends is. DON stated she does not not follow the procedure nor ing the missed doses.  If you not 1/28/21 at 6:00 p.m., RN)-A stated the night nurse for pregabalin as it was running in desk for the day nurse to ysician 2 days prior to the town on the nursing in desk down on RN-A about education, the nursing	F 7	755	responsibility of the Administrator.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	CON	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1635 WEST SERVICE DRIVE WINONA, MN 55987	•	· <b>- · · · · ·</b>
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F 755	Continued From pa	age 5	F 75	5		
		2 diabetes mellitus without chronic kidney disease.				
		uded, "[R7] has diabetes oral medication as well as daily				
	(MAR) identified th 9/15/2020, the MAI and initial documer glipizide 2.5mg had	edication administration record e physician order; on R had a box with a check mark nted which indicated the d been administered. On R had a box with nothing				
	:Seen today by [Ph New orders:3) S	dated 9/14/20 included, "Order nysician-A] for a regulatory visit. start Glipizide [an oral cation] 2.5mg qAM [every kfast"				
	glipizide not here called they will be stoday. [Nurse Pracdiscussed with her	e dated 9/16/20 included, " from the pharmacy, pharmacy sending these meds later titioner-A] here this was she states to start these to tomorrow. vital signs seed."				
	identified R7's glipi physician's order of indicated not given (blood sugar) this A measure taken to p Pharmacy called a (medication) will be provider notified No	Event Report dated 9/16/2020, izide was not administered per in 9-15-20. Details of the event in Adverse effect noted BS A.M. was 193. Immediate prevent reoccurrence: and confirmed meds in series esent today. Notification provided by the				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(>	X3) DATE SURVEY COMPLETED
		245102	B. WING _			C <b>01/29/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1635 WEST SERVICE DRIVE WINONA, MN 55987	CODE	01/23/2021
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F 755	Registered Nurse: I (medications) if not reoccurrence: Triple During an interview director of nursing (a new medication to verified R7 did not reven though the M/had been administer not in the medication the glipizide had no pharmacy. The DO facility received an transcribed, and a facility received an transcribed, and a facility received the year available morning of the 9/15 would have needed they received the medication should I would have needed to get stated the medication should I arrived at 6:30 p.m. delivered to the face DON verified the provider medication should I arrived at 6:30 p.m. delivered to the face DON verified an investation in the provider and verified an investation and received the provider and verified an investation of the provider and verified an investation and received the provider and verified an investation of the provider and verified an investation and received the provider and verified an investation of the provider and verified and verifi	Do not sign out meds given. Plan to prevent e check medication.  on 1/29/21, at 12:24 p.m. the DON) stated the glipizide was a start on 9/15/20. The DON receive the glipizide on 9/15/20 AR indicated the medication was an cart to be administered, as the been delivered from the N stated the process was the order, the order was ax was sent to the pharmacy. We faxed the order over, the nave been delivered the 1/20, so the medication should be to be administered the 1/20. The DON stated she to call the pharmacy to see if order and if they did why did the medication. The DON stated dications the facility would the medication. The DON on was for the A.M. one time ted the facility should have to get direction to see if the pharmacy was not contacted to served the fax for the glipizide stigation was not available at the	F 7	55		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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F 755	written prescription when the current sunursing staff will sepharmacy.  The facility policy Ppolicy dated 11/7/1. fax copy of any writpharmacy; medicated Monday and Thurst responsible for ordering medication to be giof medication to be giof medications adminmedications adminmedications adminmedications adminmedications adminuscriptions.	for controlled substances upply is noted to be low; nd a copy of physician order to hysician's Order Transcription 2 included that the nurse will ten medication order to the ions will be ordered each day, the AM shift is ering medications given more y, and all shifts are responsible ations as needed; verify wen with regards to the 5 rights nistration and document istered.  procedure for Sterling to call Walgreens pharmacy to fill supply business day or through receiving order on a Friday. It order is for a controlled	F 75	55		
	included omission ( that is ordered but example of a media procedure included must be completed	en what was ordered and the				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 17, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: BZ1K11

#### Dear Administrator:

The above facility was surveyed on January 27, 2021 through January 29, 2021 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. 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.

Sauer Health Care February 17, 2021 Page 2

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, RN, Unit Supervisor Rochester District Office 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

Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mistago

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			;
		00705	B. WING		01/2	9/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag alle number indicated below. In the several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you	TS: I and 1/29/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				

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

**Electronically Signed** 02/25/21

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				URVEY ETED
		00705			C <b>01/29</b> /	/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	0 11 201	
			T SERVICE			
SAUER I	HEALTH CARE	WINONA,	MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
21550	substantiated: H5102030C no defi H5102029C no defi H5102029C no defi The following comp substantiated with of H5102027C substated deficiency issued w S4658.1325 Subp. H5102028C substated deficiency issued w S4658.1325 Subp. The following comp unsubstantiated H5 The facility is enrolled signature is not req page of state form.  MN Rule 4658.1325 Medications; Pharman	ciencies  laints were found to be deficiencies  ntiated with an associated ith licensing orders issued at 1 ntiated with an associated ith licensing orders issued at 1  laints was found to be 5102031C.  ed in ePOC and therefore a uired at the bottom of the first 5 Subp. 1 Adminiatration of	21550		3	3/31/21
	by: Based on interview facility failed to have identify medication	and document review the medications available, errors and notify physician were not administered per		In response to the above stated citation Sauer Health Care took immediate actions:  " Initial verbal education provided to		

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STATE FORM BZ1K11 If continuation sheet 2 of 8

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:		<u></u>	COMP	LETED
					c	<u>.</u>
		00705	B. WING		1	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			T SERVICE			
SAUER I	HEALTH CARE		MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 2	21550			
21550	orders for 2 of 3 resmedication administration administration administration administration administration administration administration administration administration and the director of nursing tre-order the medical and that is why it is the director of nursing the director of nursing tre-order the medical and that is why it is the director of nursing and that is why it is the director of nursing and November 15th HS morning and Nover 15th according to the record (MAR) the minimal statement of the director of the nursing and th	cation orders dated 10/14/20 in (used to treat nerve and ing fibromyalgia) capsule mg by mouth three times a neuropathy (is when multiple ecome damaged) due to other ance on 11/16/20 indicated abalin medication on Sunday red. It included that she was go that it was ordered on ted her feet were burning, grievance indicated that the old her that staff did not ation when they should have out. Follow up included that ng provided coaching and the medication to staff.  Ininistration record for depregabalin was not given (at bedtime) November 16th in the staff of the medication administration nedication was not available. The enter the two doses in the staff of the two doses in the staff of the two doses.	21550	Manager re: concerns related to medication errors.  " Initial investigation by DON intand R7 to determine root cause, eany and address concerns related medication errors.  " Individual counseling done wit regularly scheduled AM and PM st. LPNs  Additional actions taken by Sauer Care since 1/29/2021  " Notification provided to Provid R1 and R7 related to missed med " Mandatory Licensed Staff/TM in-service on 2/16/2021. Education provided to staff regarding Medica Administration, Pharmacy Service Medication Events  " Created Licensed Staff End of document that is to be filled out fo shift related to medication administration, barriers and resident concern DON will evaluate its effectiveness data and determine new process of forward.  " Update of the following policies of the following policies of the following policies.  Medication Administration, Geoguidelines Policy  Medication Event Policy  Physician Sorder Transcript Policy  Controlled Substances, Management in the process of the following policies.  Controlled Substances, Management in the process of the following policies.	effects if to hhift Health er for ications. A house and f Shift reach stration, erns. S, review going seneral	
	R1 face sheet inclu neoplasm of anus, syndrome, polyneur agents, restless leg	ded diagnoses of malignant fibromyalgia, and chronic pain ropathy due to other toxic		of Policy 5. Disposal of Controlled and Non-Controlled Medications Policy 6. Emergency Medication Kit (E- of and Replacement Policy " EKIT binders will be updated of current medication content	/ Kit) Use	

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	
		201251110.		^	
	00705	B. WING		O1/2	9/2021
	00703			01/2	3/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
SAUER HEALTH CARE		ST SERVICE	DRIVE		
	WINONA,	MN 55987			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21550 Continued From page	ge 3	21550			
1/12/2021 included frequency rated at 1 scheduled, as need interventions for pair R1 care plan include perirectal surgery as syndrome, restless disease, fibromyalgi included R1 will vertor ability to cope with through review date evaluate the effective with review for compaymptoms, dosing a satisfaction with resability and impact or for assistance when for medication, tell hand what increases alleviated/relieved be diclofenac (is used (inflammation), and arthritis) gel, lidocair oral medication.  During an interview LPN-A stated there medications are low to reorder prior to rupharmacy if the medication (error) error puring an interview stated she was not a was not ordered unto the schedule of the schedule of the puring an interview stated she was not a was not ordered unto the schedule of the schedule o	almost constant pain 10. MDS included R1 has ed, and non-medication in management.  ed R1 has pain related to ind diagnoses of irritable bowel legs, gastroesophageal reflux ia, and polyneuropathy. Goals balize adequate relief of pain th incompletely relieved pain is R1 interventions included veness of pain interventions pliance, alleviating of schedules, and resident fulls, impact on functional in cognition; R1 is able to call in pain, reposition self, ask now much pain is experienced or alleviates pain; R1 pain is by rest, repositioning, to relieve pain, swelling joint stiffness caused by ine patches, distractions, and  on 1/28/21 at 10:45 a.m., is a process to follow when or not available. Nursing are unning out and or call dications are not delivered on a medication is not available, becument and make a	21000	" Medication Event discussion/r added to new QAPI format for Man meeting " DON completed random samp review of 10 (25%) resident medicadministration records over the lass months. No adverse effects noted " DON or designee will complete audits of medication administration residents x 2 weeks, then weekly weeks, then monthly x 6 months to compliance and address any violative plan.  " Create Medication Re-Order F." Health Care Academy courses assigned to Licensed staff and TM Medication Administration assigned licensed staff to be completed by 3/Medication Assistance for the Medication Assistance for the Medication Assistance for the Medication Assistance for the Medication Assistance for the Medicades assigned to TMA staff to be completed by 3/31/2021.  " In March 2021, Licensed Phar Consultant will resume in person, pre-COVID audits and med pass observations.  " Education of this will be provided appropriate staff with confirmation learning to be complete on or beformarch 31, 2021  Compliance for adherence to this be the responsibility of the Directo Nursing with overall compliance be responsibility of the Administrator.	orch  oling ation  st 3  d. e daily n on 10 c 2 o ensure tion of  Policy st IA staff. d to 3/31/21. dication  of macist  led to of ore  plan will r of	

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winnesc	ita Department of He	aith				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00705	B. WING		01/2	) 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
NAME OF I	NOVIDER OR GOLF EIER		ST SERVICE			
SAUER I	HEALTH CARE	WINONA,	MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 4	21550			
	stated staff felt ther status with the miss medication event sl missed doses. DON in rounds book regastated the nurse sh if medication not aveducation with staff event. DON stated is no documentation available for the dostated [name of and pharmacy for emergmain pharmacy] us due to the pandemi 6:30 p.m. DON stated obtaining medication posted on the units know why staff did not stated in the state of the pandemi for the pandemi	staff had ordered it. DON e was no change in pain sed doses. DON stated a hould have been filed for the N stated provider was notified arding the missed doses. DON ould be informing the resident railable. DON stated she did on ordering following the she does not know why there in regarding the medication not ses missed on 11/16/21. DON other pharmacy] is the backup gencies. DON stated [name of ed to deliver twice daily but c only delivers once daily at ed there is a procedure for ons after hours and weekends be DON stated she does not not follow the procedure nor get the missed doses.				
	registered nurse (R had printed script for out and placed it or have signed by phy missed dose and it said when asked at staff was coached on R7 R7's facility Admiss diagnoses of type 2 complications and on R7's care plan included.	ion Record, included diabetes mellitus without chronic kidney disease.				
	mellitus and takes of insulin."	oral medication as well as daily				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00705	B. WING			C <b>29/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SAUER	HEALTH CARE		ST SERVICE I MN 55987	DRIVE			
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21550	R7's September me (MAR) identified the 9/15/2020, the MAF and initial documen glipizide 2.5mg had 9/16/2020, the MAF documented.  R7's provider note of Seen today by [Phy New orders:3) Stanti-diabetic medical morning] with break R7's progress noteglipizide not here called they will be stoday. [Nurse Pract discussed with her, meds (medications obtained and charter Facility Medication identified R7's glipiz physician's order or indicated not given. (blood sugar) this Ameasure taken to pharmacy called ar (medication) will be provider notified Nuduring rounds. Edur Registered Nurse: I (medications) if not reoccurrence: Triple During an interview director of nursing (	edication administration record e physician order; on R had a box with a check mark ted which indicated the been administered. On R had a box with nothing dated 9/14/20 included, "Order vsician-A] for a regulatory visit. Fart Glipizide [an oral ation] 2.5mg qAM [every cfast"  dated 9/16/20 included, "from the pharmacy, pharmacy ending these meds later itioner-A] here this was she states to start these tomorrow. vital signs ed."  Event Report dated 9/16/2020, ride was not administered per in 9-15-20. Details of the event Adverse effect noted BS in.M. was 193. Immediate revent reoccurrence:	21550				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:				
		00705	B. WING		01/2	9/2021	
NAME OF PROVIDER OR SUPP	LIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SAUER HEALTH CARE			ST SERVICE	DRIVE			
OLD ID	V CT/		MN 55987	DDOVIDEDIC DI ANI OF CODDECTI		0.(5)	
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)				(X5) COMPLETE DATE		
21550 Continued Fro	n pa	ige 6	21550				
even though the had been admedication the medication should have needed the stated the medication should have needed the have needed the have needed the stated the medication should have needed the stated the medication should have needed the stated the medication should have needed the stated the provent of the provent	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  even though the MAR indicated the medication had been administered, as the medication was not in the medication cart to be administered, as the glipizide had not been delivered from the pharmacy. The DON stated the process was the facility received an order, the order was transcribed, and a fax was sent to the pharmacy. The DON stated if we faxed the order over, the medication should have been delivered the evening of the 9/14/20, so the medication should have been available to be administered the morning of the 9/15/20. The DON stated she would have needed to call the pharmacy to see if they received the order and if they did why did the facility not get the medication. The DON stated R7 needed the medication was for the A.M. one time dose. The DON stated the facility should have called the provider to get direction to see if the medication should be administered when it arrived at 6:30 p.m. when it would had been delivered to the facility from the pharmacy. The DON verified the pharmacy was not contacted to see if they had received the fax for the glipizide and verified an investigation was not available at the facility for administration.  The facility policy Management of Controlled Substances dated 5/12/15, included in the procedure for nursing staff to request a new written prescription for controlled substances when the current supply is noted to be low; nursing staff will send a copy of physician order to						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00705	B. WING		01/2	) 9/2021		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SAUER	HEALTH CARE		T SERVICE MN 55987	DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
21550	pharmacy; medicat Monday and Thurso responsible for order than one time a day for ordering medication to be given of medication to be given of medication adminimedications adminimedications adminimedications adminimedications adminimedications adminimedications adminimedications adminimedications adminimedication adminimedication for a medication adminimedication adminimedication adminimedication adminimedication adminimedication errors. The director of nursively and develop a monimedication were orgorectly. The qualimenitor these measures.	ions will be ordered each day, the AM shift is ering medications given more a, and all shifts are responsible ations as needed; verify wen with regards to the 5 rights nistration and document stered.  procedure for Sterling I to call Walgreens pharmacy. greens pharmacy to fill supply business day or through receiving order on a Friday. It order is for a controlled tire quantity.  cation Event dated 12/6/19 missed medication) of a drug not administered as an cation event. Medication event that a medication event report for any medication en what was ordered and the	21550					

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