

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 17, 2021

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

RE: CCN: 245102

Cycle Start Date: October 22, 2021

Dear Administrator:

On December 8, 2021, we notified you a remedy was imposed. On December 9, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 3, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 22, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed 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

M. Jag

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 3, 2021

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

RE: CCN: 245102

Cycle Start Date: October 22, 2021

#### Dear Administrator:

On October 22, 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 November 3, 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), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

#### 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 January 22, 2022 (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).

Sauer Health Care November 3, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by April 22, 2022 (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 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/04/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245102	B. WING		C <b>10/22/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1635 WEST SERVICE DRIVE WINONA, MN 55987	1 10/2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs .	F 000			
	conducted at your f to be NOT in compl	ndard abbreviated survey was acility. Your facility was found liance with the requirements of art B, Requirements for Long s.				
	SUBSTANTIATED:	laint was found to be 077571) with a deficiency				
	as your allegation of Departments acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	onsite revisit of you	acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained.	F 684		1	12/3/21
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro- practice, the compri care plan, and the r	fundamental principle that the sent and care provided to assed on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered				
ABORATORY	' DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	C	X6) DATE

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

(X6) DATE

**Electronically Signed** 

11/15/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245102	B. WING		1	C <b>22/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/2	
				1635 WEST SERVICE DRIVE		
SAUER I	HEALTH CARE			WINONA, MN 55987		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		TION JLD BE OPRIATE	(X5) COMPLETION DATE
F 684	F 684 Continued From page 1		F 684	1		
	review the facility fa assess and monito dehydration for 2 or	tion, interview, and document ailed to comprehensively r for fluid overload and/or f 3 residents (R1 and R3) administered diuretic		In response to the above stated Sauer Health Care took immedia actions:  • Meeting with RN Unit Manag RN MDS Coordinator regarding to the state of t	er and	
	Findings include  R1's cardiac care plan dated 4/18/2019, identified R1 had altered cardiovascular status related to cardiac diagnoses including congestive heart failure. The care plan interventions included daily weights to monitor fluid status and monitor/document/report to physician signs and symptoms such as shortness of breath, dependent edema, and color/warmth changes in extremities.  R1's physician visit dated 9/10/21, the note indicated R3 should drink plenty of water.			of citation  Reviewed all residents receiving diuretics to ensure proper monitoring is in place if necessary.  Initial investigation was completed by DON into R1 and R3 to determine root causes, effects if any and addressed concerns with provider  Review of R1, R2 and R3 by unit manager and comprehensive chart note entered on current status by 11/16/2021.  Review of the following policies and protocols to include updates and creation of policies where needed  Redema monitoring  Dehydration-Hydration Clinical Protocol		
	lower extremity] ed (compression netting but is a daily weigh record did not inclusted evaluation of R1's extra R1's emergency deducted 9/24/21, indiction with hypotension and included "She [R1] as her lactic acid wourea, nitrogen lab to elevated. We have of IV [intravenous]	A1 had edema, "BLE [bilateral ema, refuses to wear tubigrip ing used to control swelling), it and takes diuretics. R1's de a comprehensive edema.  Expartment discharge summary cated R1 presented to hospital ind back pain. The summary does appear to be dehydrated is elevated and BUN [bun, est] and creatinine were rehydrated her with 2 L [liter] fluids which she tolerated in also gave new orders to		<ul> <li>3. CHF-Heart Failure-Clinical P</li> <li>4. Fluid Balance—Hydration Cl Protocol</li> <li>Plan to address any future non-compliance.</li> <li>Health Care Academy course assigned to Licensed staff and T to be completed by 12/3/2021</li> <li>¿ Nutritional promotion in the of ¿ Dehydration prevention</li> <li>¿ Chronic kidney disease</li> <li>¿ CHF</li> <li>¿ Recognizing and reporting cl resident condition (this is completed annually, along with annual reviewed change in condition policy)</li> </ul>	es MA staff older adult nanges in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
		245102	B. WING			C <b>22/2021</b>	
	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP 1635 WEST SERVICE DRIVE WINONA, MN 55987	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	decrease her Lasis daily.  R1's Provider's Or 9/24/21, indicated care and returned Lasix to 40 mg dai pressure medicatic to re-evaluate medicate that reside be encouraged to R1's physician Or 9/28/21, included the encourage fluid in dehydration -Lasix 40 mg one of failure -Spironolactone 12 day for congestive R1's record lacked monitoring after the medication and lack intake monitoring after the medication and	der progress note dated R1 had been seen at urgent with orders to 1) decrease ly, 2) decrease lisinopril (blood on) to 10 mg daily 4) physician lication in one week. A ated 9/24/21 included "Labs ent was dehydrated and should drink more fluids."  Her Summary Report dated the following: ed to heart failure stake, every shift for time a day for congestive heart	F 6	<ul> <li>Provide education on emonitoring, dehydration, C balance policy and/or protelicensed nurses and TMAs signature of understanding</li> <li>Updated nursing admito ensure activation of CHI dehydration protocols for mospital returns</li> <li>Create order templates monitoring of edema, dehy and fluid balance by 12/3/2</li> <li>Completed tracking to including pictures and mea 11/13/2021. Will distribute education to affected by 12</li> <li>Facility is exploring op available assessments and tools within current EMR (Fare).</li> <li>Care plans reviewed for R2 and R3, updates done 12/3/2021.</li> <li>Audits to be completed month and then monthly x ensure compliance.</li> <li>Overall compliance to completed by 12/3/2021</li> <li>Compliance for adherence be the responsibility of the Nursing with overall compliresponsibility of the Administration.</li> </ul>	HF and fluid pools to sevidence is by 12/3/2021 ssion checklist F and new admits and se for proper adration, CHF 2021. Following the second of fluids assurements on and provide 2/3/2021. Following the point Click for residents R1, if necessary by the second of the sec		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245102	B. WING _		10	C / <b>22/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 1635 WEST SERVICE DRIVE WINONA, MN 55987		72272021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	percentages of 1-2 76-100%. The reco percentage of the t amount of fluid con R1's weekly progre indicated R1 did no R1's Provider's Orc 9/29/21, indicated R to address recent r hypotension and ur indicated R1's weig had improved (the for comparison to r from and did not m improvement of the indicated R1's bloo twice daily blood pr implemented, and R1's physician visit reason or visit was blood pressures. T history of emergen	5%, 26-50%, 51 to 75%, or ord did not identify the otal fluid offered or the total issumed.	F 68	,			
	"Patient did have a when seen in the E orders to decrease R1's physician ordediscontinue Lasix 4 every morning related After R1's order challed did and fluid into the seen and fluid into the seen in the E order of the seen and fluid into the seen in the E order of the E	cute on chronic kidney injury ED." The note also indicated Lasix to 20 mg daily.  ers dated 10/4/21, included 1) to mg, 2) Start Lasix 20 mg ted to congestive heart failure.  ange to further decrease the R1's record continued to lack take monitoring and evaluation.  dated 10/4/21, included, "Her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l .	FIPLE CONSTRUCTION  NG	CON	(X3) DATE SURVEY COMPLETED	
245102		B. WING			C 10/22/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1635 WEST SERVICE DRIVE WINONA, MN 55987	· · · · · · · · · · · · · · · · · · ·	7. Z.Z. 7. Z.Z
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	water pitcher remai water pass. Encour did take a drink whi Wil continue to mor R1's progress note R1's family membe bottle of water.  R1's emergency de dated 10/11/21, included the orders medication and Las "It is very important fluid and increasing days. Drink 4 ounce awake (and more if R1's MAR reviewed identified the hospit MAR included the ronsumed every 2 consumed were no record also continu monitoring after the R1's social services 10/12/21, indicated and dietary was infeand "She was offer today and just want R1's social services 10/13/21, indicated R1's physician order R1's physician phys	respectively. The state of the second and after 10/11/21 and or and after 10/11/21 and or and after 10/11/21 and or and after 10/11/21 and order for fluid intake; the number of ounces R1 hours, however all fluid totals to calculated or evaluated. The ed to lack ongoing edema and included that you are drinking enough to all intake over next several es of fluid every 2 hours while a table).  If on and after 10/11/21 and order for fluid intake; the number of ounces R1 hours, however all fluid totals to calculated or evaluated. The ed to lack ongoing edema and included and after 10/11/21 and order for fluid intake; the number of ounces R1 hours, however all fluid totals to calculated or evaluated. The ed to lack ongoing edema and included and included R1 "was encouraged to drink ormed she was ready to eat." ed several options for liquid	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245102	B. WING _			C / <b>22/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1635 WEST SERVICE DRIVE WINONA, MN 55987		1212021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	R1's social services 10/14/21, included A subsequent Provindicated the physic "is drinking poorly. options for snacks declines.  R1's weekly summindicated R1 did not R1's physician order continued hold on subsequent Proving an interview director of nursing emergency room virtual monitoring for dehy holding the medica DON indicated prioremergency room virtual recorded in percentindicated R1's fluid evaluated. DON indicated R1's fluid evaluated. DON indicated R1's fluid evaluated. DON indicated Consumed should buring an interview nursing assistant (If fluids every two hostime on a dry erase stated we estimate drank. NA-A stated assistance would wirecord the fluids drank of the subsequence of the fluids drank of the fluids dran	s progress note dated "She is drinking some fluids". ider Order progress note cian had reviewed labs and R1 Staff have offered multiple and beverages but she  ary note dated 10/18/21, ot have edema.  ers dated 10/20/21, directed spironolactone and Lasix.  on 10/22/21, at 9:00 a.m. (DON) indicated after R1's isit on 9/24/21, the facility was ordration by offering fluids, tions, and monitoring labs. or to and after to R1's isit on 9/24/21, fluid intake was tages after meals and consumption was not dicated after her ER visit on offered 4 ounces of fluid every mount was recorded on the the total daily intake be documented.  on 10/22/21, at 2:46 p.m. NA)-A stated staff encouraged urs and would write down the board by R1's door. NA-A and document how much she the dietary aides and nursing work together after meals to ank in percentages. NA-A ness if the total amount of R1	F 68	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245102		` '	` ′	) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245102	B. WING _		10	C / <b>22/2021</b>	
	NAME OF PROVIDER OR SUPPLIER  SAUER HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP 1635 WEST SERVICE DRIVE WINONA, MN 55987		10/22/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	registered nurse (F medication assista R1 consumed ever indicated the amoud documented in per much total fluid was tated she would h RN-A indicated if the documented it coul how much total flui indicated if residen should be monitoridocumentation need and amount. RN-A edema was not deevaluated for improstated descriptive retermine a chang treatments or medicated record, RN-A indicated impact the rediuretic medication of econsistent assession the documentation of econsistent assession the documentation currently had lower During an interview medical doctor (MI nursing be encouraevaluate fluid volureffectiveness of treestrees.)	on 10/22/21, at 3:02 p.m. RN)-A stated nurse or trained nt (TMA) recorded the amount ry 2 hours on the MAR. RN-A ant consumed for meals was centages. When asked how s offered at each meal, RN-A ave to check with dietary staff. The amounts were not lid not easily be determined dietary was consumed. RN-A at the had edema, then the nurse right and documenting; and documenting; and documenting; and to include specific location and indicated if the extent of the scribed it could not be extend or worsening. RN-A motes were necessary to be or the effectiveness of ications. RN-A reviewed R1's attend the record lacked edema monitoring and ments. RN-A indicated based ion it could not be determined duced and discontinued as had on R1's edema or if R1 rextremity edema.  To 10/22/21, at 3:23 p.m. D)-A indicated an expectation aging fluid and record and me status and for the eatments.	F 68	34			
	at 4:09 p.m. R1 safeet on the floor, ar	tion and interview on 10/22/21, t in a chair in her room, her nd both ankles were observed A asked R1 if she could look at					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245102	B. WING _		10	C / <b>/22/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1635 WEST SERVICE DRIVE WINONA, MN 55987		IZZIZOZ I	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	ankle aspects had to +1 edema in her stated R1's right for left; R1 had 3-4+ pi aspects and trace.  During an interview director of nursing monitored/assesse resident, for a stabl assessed on show was a change then notified, and evaluate more frequently. Do for edema needed indicated an expectand symptoms of dat risk.  R3 R3's dietary care plindicated R3 had a fluid volumes related dependent edema, care plan included encourage adequated R3's cardiac care printerventions for dat document any ederappropriate.  R3's quarterly Minit 8/26/21, indicated Frequired extensive member for dressir diuretic medications.	nted. RN-A stated R1's left 2-3+ pitting edema and trace foot to mid shin level. RN-A of had more swelling than the titing edema in her right ankle 1+ to the foot to mid shin level.  If on 10/22/21, at 4:27 p.m.  (DON) indicated edema was dependent upon individual eresident edema was er day. DON indicated if there the physician would be ations would be completed DN indicated documentation to be descriptive. DON tation nursing monitor for signs ehydration daily for residents  an dated 10/28/2015, nutritional risk and variable and diuretic use. The dietary intervention dated 4/8/2020, to be fluid intake on a daily basis. Ilan dated 5/2/2017, included ily weights and monitor and ma, notify physician when	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER.		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245102	B. WING _		10	C / <b>22/2021</b>	
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP 1635 WEST SERVICE DRIVE WINONA, MN 55987		122/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	localized edema, vechronic kidney dise orders for knee hig morning and off at related to edema, a 40 milligrams (mg)  R3's progress note continued to compl discomfort, presum This has not respondelevation. New orde 60 mg every morning failure.  R3's record consist and evaluation of the increased do R3's progress note had pain in both her hips. The note included diuretics, elevation. The sect to describe edema, left blank.  R3's record did not 10/20/21. R3's progincluded "chronic B wears compression not specify the local did not evaluate the edema had worsen.	ol/11/21, included diagnosis of enous insufficiency, and ase. The listing included h compression socks on in the night, weight one time a day and Lasix (diuretic medication) every morning.  dated 10/11/21, included R3 ain of foot and lower extremity hably related to her edema. Inded to using compression or ears given to increase Lasix to an related to congestive heart the effectiveness or side effects are of Lasix.  dated 10/13/21, indicated R3 are feet and chronic joint pain in indicated interventions rest, compression, and ion of the note that prompted location, and treatment was mention edema until gress note dated 10/20/21, indicated interventions rest, compression, and ion of the note that prompted location, and treatment was mention edema until gress note dated 10/20/21, indicated interventions rest, compression, and ion of the note that prompted location, and treatment was mention edema until gress note dated 10/20/21, indicated interventions of edema on R3's legs, extent, and did not assess if	F 68	34			
	Registered nurse (I	7 on 10/22/21, at 3:02 p.m. RN)-A indicated if residents the nurse should be monitoring					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245102	B. WING	i	1	C <b>0/22/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1635 WEST SERVICE DRIVE WINONA, MN 55987		0/22/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 684	and documenting; include specific loc indicated if the exterior described it could rimprovement or word descriptive notes word change or the effect medications. RN-A indicated the record edema monitoring RN-A indicated base could not be determincreased dose of light During an interview medical doctor (MI nursing be monitor status and for the extension of the ex	documentation needs to ation and amount. RN-A ent of the edema was not not be evaluated for presening. RN-A stated were necessary to determine a ctive of treatments or reviewed R3's record, RN-A d lacked documentation of and consistent assessments. Seed on the documentation it nined what impact the Lasix has had on R3's edema.  On 10/22/21, at 3:23 p.m. O)-A indicated an expectation ing and evaluating fluid volume effectiveness of treatments.		584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG	COV	(X3) DATE SURVEY COMPLETED	
245102		B. WING _		l	C <b>10/22/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1635 WEST SERVICE DRIVE WINONA, MN 55987		, LL, LUL 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	was a change then notified, and evalua more frequently. Do for edema needed	the physician would be tions would be completed DN indicated documentation	F 6	34		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 3, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: WHLO11

#### Dear Administrator:

The above facility was surveyed on October 22, 2021 through October 22, 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 November 3, 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:

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

M. Flig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 ti Boilebiirto.		C	
		00705	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAUER I	HEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment 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.					
	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 nin 15 days of receipt of a nt for non-compliance.				
	at your facility by su Department of Heal found NOT in comp Licensure. Please in of correction you ha	rS: aplaint survey was conducted inveyors from the Minnesota lth (MDH). Your facility was eliance with the MN State indicate in your electronic planate reviewed these orders and en they will be completed.				

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

**Electronically Signed** 11/15/21

STATE FORM 6899 If continuation sheet 1 of 13 WHLO11

TITLE

(X6) DATE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00705	B. WING		10/2	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALIEDI	IEALTH CADE	1635 WES	T SERVICE	DRIVE		
SAUER	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
2 000	The following comp SUBSTANTIATED: with a licensing ord  The Minnesota Dep documenting the St Orders using Feder have been assigned statutes/rules for Nitag number appear. "ID Prefix Tag." The compliance is listed of Deficiencies" cold Comply" portion of column also include violation of the state "This Rule is not me the surveyor's find Method of Correction. You have agreed to receipt of State lice the Minnesota Depainformational Bullet <a href="https://www.healthon/infobulletins/ib14">https://www.healthon/infobulletins/ib14</a> orders are delineated.	plaint was found to be H5102034C (MN00077571) er issued at 0830.  partment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned is in the far-left column entitled e state statute/rule out of in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following lings are the Suggested on and Time Period for e participate in the electronic insure orders consistent with	2 000			
	is necessary for Sta enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depart	Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to part the stand therefore a signature is				
		and therefore a signature is bottom of the first page of				

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 2 of 13

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
			A. BUILDING.		С
		00705	B. WING		10/22/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
SAUER I	HEALTH CARE		T SERVICE MN 55987	DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE	2 000		
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830		12/3/21
	by: Based on observati review the facility fa assess and monitor dehydration for 2 of reviewed that were medications.  Findings include R1's cardiac care p	ent is not met as evidenced on, interview, and document illed to comprehensively for fluid overload and/or 3 residents (R1 and R3) administered diuretic lan dated 4/18/2019, identified diovascular status related to		In response to the above stated citat Sauer Health Care took immediate actions:  • Meeting with RN Unit Manager a RN MDS Coordinator regarding findicitation  • Reviewed all residents receiving diuretics to ensure proper monitoring place if necessary.  • Initial investigation was complete.	nd ngs of ı is in

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 3 of 13

	alth			
AND DIAN OF CORRECTION IN TRENTIFICATION NUMBER: IN A COMPLETE COM		(X3) DATE SURVEY COMPLETED		
, and i Exart of Gorange mon	ibertii io, triott ttombert.	A. BUILDING:		JOHN ELTEB
		D. WINO		С
	00705	B. WING		10/22/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
	1635 WES	T SERVICE	DRIVE	
SAUER HEALTH CARE	WINONA,			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 830 Continued From pag	је 3	2 830		
cardiac diagnoses in failure. The care plan weights to monitor/flocument/resymptoms such as sidependent edema, a extremities.  R1's physician visit dindicated R3 should  R1's weekly summan 9/20/21 indicated R1 lower extremity] eder (compression netting but is a daily weight a record did not include evaluation of R1's eder and included "She [R1] das her lactic acid was urea, nitrogen lab testelevated. We have resof IV [intravenous] flowell." The physician decrease her Lasix fidaily.  R1's Provider's Orde 9/24/21, indicated R1 care and returned with Lasix to 40 mg daily, pressure medication to re-evaluate medic subsequent note date	including congestive heart in interventions included daily uid status and export to physician signs and shortness of breath, and color/warmth changes in dated 9/10/21, the note drink plenty of water.  Ty progress note dated I had edema, "BLE [bilateral ma, refuses to wear tubigrip gused to control swelling), and takes diuretics. R1's the a comprehensive dema.  The progress nate do hospital do back pain. The summary loes appear to be dehydrated is elevated and BUN [bun, st] and creatinine were ehydrated her with 2 L [liter] uids which she tolerated also gave new orders to from 80 mg daily to 40 mg  The progress note dated t	2 630	DON into R1 and R3 to determine causes, effects if any and address concerns with provider  Review of R1, R2 and R3 by unanager and comprehensive charentered on current status by 11/16  Review of the following policie protocols to include updates and of policies where needed  Bedema monitoring  Dehydration-Hydration Clinical Protocol  CHF-Heart Failure-Clinical Protocol  Review of the following policie protocols to include updates and of policies where needed  Edema monitoring  Dehydration-Hydration Clinical Protocol  Review of the following policie protocols  CHF-Heart Failure-Clinical Protocol  Realth Care Academy courses assigned to Licensed staff and TM to be completed by 12/3/2021  Nutritional promotion in the old Dehydration prevention  Chronic kidney disease  CHF  Recognizing and reporting charesident condition (this is complete annually, along with annual review change in condition policy)  Provide education on edema monitoring, dehydration, CHF and balance policy and/or protocols to nurses and TMAs evidence is sign understanding by 12/3/2021  Updated nursing admission charent condition protocols for new adminospital returns  Create order templates for promonitoring of edema, dehydration,	anit rt note rt note r/2021. s and creation  I  otocol ical  S IA staff der adult  anges in ed r of  fluid licensed nature of necklist  nits and oper

STATE FORM 6899 If continuation sheet 4 of 13 WHLO11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	00705	B. WING		10/22/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
SAUER HEALTH CARE		T SERVICE MN 55987	DRIVE	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
9/28/21, included the -Daily weight related -Encourage fluid in dehydration -Lasix 40 mg one to failure -Spironolactone 12 day for congestive R1's record lacked monitoring after the medication and lack intake monitoring and effectiveness of flue R1's medication and reviewed from 9/24 physician order to eshift; the record idea completed by a cheshift box. The documentation was R1 consumed documentation was R1 consumed during percentages of 1-2 76-100%. The record percentage of the tamount of fluid con R1's weekly progresindicated R1 did not R1's Provider's Orce 9/29/21, indicated R1 to address recent record reco	er Summary Report dated ne following: d to heart failure take, every shift for time a day for congestive heart .5 mg by mouth one time a heart failure.  ongoing consistent edema decrease in diuretic ked comprehensive fluid and evaluation to determine id encouragement intervention.  Iministration record (MAR) .21 to 10/10/21 identified the encourage fluid intake every entified the task/order was eckmark in the corresponding mentation did not include alt of the encouragement, or . R1's Point of Care fluid intake is reviewed, the amount of fluiding each meal was identified by 5%, 26-50%, 51 to 75%, or ord did not identify the otal fluid offered or the total sumed.	2 830	Completed tracking tool of flui including pictures and measureme 11/13/2021. Will distribute and proeducation to affected by 12/3/2020. Facility is exploring options of available assessments and monito tools within current EMR (Point Cl Care). Care plans reviewed for reside R2 and R3, updates done if neces 12/3/2021. Audits to be completed weekly month and then monthly x 3 month ensure compliance. Overall compliance to D684 to completed by 12/3/2021  Compliance for adherence to this be the responsibility of the Directo Nursing with overall compliance be responsibility of the Administrator.	ents on ovide 1. oring ick ents R1, esary by y x 1 hs to o be plan will r of

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00705	B. WING		<b>I</b>	C <b>22/2021</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10/2	
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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	had improved (the for comparison to r from and did not m improvement of the indicated R1's blood twice daily blood primplemented, and pR1's physician visit reason or visit was blood pressures. Thistory of emergency and dehydration-he "Patient did have as when seen in the Eorders to decrease R1's physician order discontinue Lasix 4 every morning related After R1's order characteristic medication edema and fluid interpretation. R1's progress note water pitcher remains water pass. Encound did take a drink who will continue to more R1's family member bottle of water.  R1's emergency decidated 10/11/21, incomplete injury and hyincluded the orders.	record did not identify a date eference the improvement ention an extent of the edema). The note also d pressures remained low, essure monitoring was ohysician to review next week.  note dated 10/4/21, indicated for re-evaluation of R1's low he note recapped recent by room visit for hypotension er lactic acid was elevated cute on chronic kidney injury D." The note also indicated Lasix to 20 mg daily.  Pers dated 10/4/21, included 1) 0 mg, 2) Start Lasix 20 mg ared to congestive heart failure.  Ange to further decrease the R1's record continued to lack ake monitoring and evaluation.  dated 10/4/21, included, "Her ins full from change over to raged to drink more water and alle this nurse was in the room.	2 830			

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 6 of 13

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00705	B. WING	<del></del>		C
		00705	B. WING		10/2	22/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAUER I	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa		2 830			
	fluid and increasing	that you are drinking enough oral intake over next several es of fluid every 2 hours while able).				
	identified the hospit MAR included the n consumed every 2 l	on and after 10/11/21 all order for fluid intake; the number of ounces R1 hours, however all fluid totals				
	record also continue monitoring after the	t calculated or evaluated. The ed to lack ongoing edema diuretics were put on hold.				
	10/12/21, indicated and dietary was info	s progress note dated R1 "was encouraged to drink ormed she was ready to eat." ed several options for liquid ed water."				
		s progress note dated R1 "is drinking fluids".				
		rs dated 10/14/21, directed pironolactone and Lasix.				
	10/14/21, included 'A subsequent Provi indicated the physic 'is drinking poorly.	s progress note dated 'She is drinking some fluids". der Order progress note sian had reviewed labs and R1 Staff have offered multiple and beverages but she				
	R1's weekly summa indicated R1 did no	ary note dated 10/18/21, t have edema.				
		rs dated 10/20/21, directed pironolactone and Lasix.				
	During an interview	on 10/22/21, at 9:00 a.m.				

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 7 of 13

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00705	B. WING		l l	C <b>22/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAUER	HEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	director of nursing (emergency room vimonitoring for dehy holding the medicat DON indicated prioremergency room virecorded in percent indicated R1's fluid evaluated. DON indicated ToON indicated DON indicated and indicated consumed should be During an interview nursing assistant (North fluids every two houtime on a dry erase stated we estimate drank. NA-A stated assistance would we record the fluids drastated an unawarer consumed was calconsumed was calconsumed every indicated the amound documented in percent total fluid was stated she would hard RN-A indicated if the documented it could how much total fluid indicated if resident should be monitoring documentation neer to the state of the should be monitoring documentation neer total fluid indicated if resident should be monitoring documentation neer total fluid indicated in percent total fluid indicated if resident should be monitoring documentation neer total fluid indicated in percent total fluid indicated if resident should be monitoring documentation neer total fluid indicated in percent total fluid indicated if resident should be monitoring documentation neer total fluid indicated in percent total fluid indicated	DON) indicated after R1's sit on 9/24/21, the facility was dration by offering fluids, tions, and monitoring labs. It to and after to R1's sit on 9/24/21, fluid intake was ages after meals and consumption was not licated after her ER visit on ffered 4 ounces of fluid every ount was recorded on the the total daily intake the documented.  In 10/22/21, at 2:46 p.m. IA)-A stated staff encouraged ars and would write down the board by R1's door. NA-A and document how much she the dietary aides and nursing ork together after meals to ank in percentages. NA-A tress if the total amount of R1	2 830			

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 8 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		A. BOILDING.	<del></del>		С
	00705	B. WING			22/2021
NAME OF PROVIDER OR SUPPLIEF	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
SAUER HEALTH CARE		ST SERVICE , MN 55987	DRIVE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
evaluated for improstated descriptive determine a change treatments or medication of consistent assess on the documentation of consistent assess on the documentation what impact the rediuretic medication currently had lower divided by the medical doctor (Minuring an interview medical doctor (Minuring be encour evaluate fluid volume effectiveness of the floor, and to be swollen. RN-her legs, R1 constantly aspects had to +1 edema in he stated R1's right for left; R1 had 3-4+ paspects and trace.  During an interview director of nursing monitored/assess resident, for a state assessed on show was a change the notified, and evaluation for edema needed.	escribed it could not be ovement or worsening. RN-A notes were necessary to ge or the effectiveness of lications. RN-A reviewed R1's rated the record lacked edema monitoring and ments. RN-A indicated based tion it could not be determined educed and discontinued as had on R1's edema or if R1 or extremity edema.  W on 10/22/21, at 3:23 p.m. D)-A indicated an expectation aging fluid and record and me status and for the				

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 9 of 13

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00705	B. WING		10/2	) 2/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	
SAUER I	HEALTH CARE		ST SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	and symptoms of dat risk.  R3 R3's dietary care plindicated R3 had a fluid volumes related dependent edema, care plan included encourage adequated R3's cardiac care pinterventions for data document any ederappropriate.  R3's quarterly Minimal R26/21, indicated Frequired extensive member for dressing diuretic medications.  R3's Physician Ord the physician on 10 localized edema, vechronic kidney diseorders for knee high morning and off at related to edema, a 40 milligrams (mg).  R3's progress note continued to completion discomfort, presum This has not responselevation. New order	ehydration daily for residents  an dated 10/28/2015, nutritional risk and variable ed to fluctuating weight, and diuretic use. The dietary intervention dated 4/8/2020, to the fluid intake on a daily basis. Islan dated 5/2/2017, included ily weights and monitor and ma, notify physician when  mum Data Set (MDS) dated R3 had intact cognition, assistance from one staff ng, and was administered s.  er Summary report signed by i/11/21, included diagnosis of enous insufficiency, and ase. The listing included in compression socks on in the night, weight one time a day and Lasix (diuretic medication)	2 830			
		ently lacked edema monitoring ne effectiveness or side effects				

Minnesota Department of Health STATE FORM

ATE FORM WHLO11 If continuation sheet 10 of 13

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00705	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAUER I	HEALTH CARE		T SERVICE MN 55987	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	of the increased do	se of Lasix.				
	had pain in both he her hips. The note i included diuretics, r elevation. The secti	dated 10/13/21, indicated R3 r feet and chronic joint pain in ndicated interventions rest, compression, and ion of the note that prompted location, and treatment was				
	10/20/21. R3's progincluded "chronic B wears compression not specify the loca	mention edema until gress note dated 10/20/21, LE [bilateral lower extremity] a stockings daily. The note did tions of edema on R3's legs, e extent, and did not assess if ed or improved.				
	Registered nurse (I have edema, then the and documenting; of include specific local indicated if the extendescribed it could not improvement or word descriptive notes where the effect medications. RN-A indicated the record edema monitoring a RN-A indicated bas could not be determined in the record indicated the record edema monitoring a RN-A indicated bas could not be determined in the record indicated bas could not be determined in the record in the record indicated bas could not be determined in the record in the	on 10/22/21, at 3:02 p.m. RN)-A indicated if residents the nurse should be monitoring documentation needs to ation and amount. RN-A ent of the edema was not not be evaluated for resening. RN-A stated ere necessary to determine a stive of treatments or reviewed R3's record, RN-A dilacked documentation of and consistent assessments. ed on the documentation it nined what impact the lasix has had on R3's edema.				
	medical doctor (MD nursing be monitori	on 10/22/21, at 3:23 p.m.  a)-A indicated an expectation  ng and evaluating fluid volume  ffectiveness of treatments.				

6899

Minnesota Department of Health STATE FORM

WHLO11 If continuation sheet 11 of 13

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00705	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	During an observat R3 sat in her wheel in dependent positic compression socks were observed to be to look at her swelling. RN-A took off R3's R3 had +4 pitting effoot to just below the legs started feeling indicated the swelling indicated assessed on shower was a change then notified, and evaluation reduced the swelling indicated in swelling indicated in the swelling in the swelling i	ion on 10/22/21, at 3:59 p.m. chair in her room with her legs on (down) and had on. R3's lower extremities e edematous. RN-A asked R3 ng in her legs; R3 consented. socks and shoes, RN-A stated dema on both her legs from the knee. R3 stated that her tired when she walked. R3 ng used to go down a little at last couple of months it seems worse in the morning than they are in the morning than they are day. DON indicated edema was the physician would be completed DN indicated documentation	2 830			

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 12 of 13

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00705	B. WING		10/2	2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAUER I	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
2 830	Continued From pa	ge 12	2 830			
	facility's quality ass	urance program.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				

Minnesota Department of Health

STATE FORM 6899 WHLO11 If continuation sheet 13 of 13