DEPARTMENT OF HEALTH

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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:

- 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).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. BUILDING _____ B. WING _____	C 10/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/22/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5102034C (MN00077571) with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		12/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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F 684	Continued From page 1 Based on observation, interview, and document review the facility failed to comprehensively assess and monitor for fluid overload and/or dehydration for 2 of 3 residents (R1 and R3) reviewed that were administered diuretic medications. 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. R1's weekly summary progress note dated 9/20/21 indicated R1 had edema, "BLE [bilateral lower extremity] edema, refuses to wear tubigrip (compression netting used to control swelling), but is a daily weight and takes diuretics. R1's record did not include a comprehensive evaluation of R1's edema. R1's emergency department discharge summary dated 9/24/21, indicated R1 presented to hospital with hypotension and back pain. The summary included "She [R1] does appear to be dehydrated as her lactic acid was elevated and BUN [bun, urea, nitrogen lab test] and creatinine were elevated. We have rehydrated her with 2 L [liter] of IV [intravenous] fluids which she tolerated well." The physician also gave new orders to	F 684	In response to the above stated citation Sauer Health Care took immediate actions: • Meeting with RN Unit Manager and RN MDS Coordinator regarding findings 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 1. Edema monitoring 2. Dehydration-Hydration Clinical Protocol 3. CHF-Heart Failure-Clinical Protocol 4. Fluid Balance—Hydration Clinical Protocol Plan to address any future non-compliance. • Health Care Academy courses assigned to Licensed staff and TMA staff to be completed by 12/3/2021 ¿ Nutritional promotion in the older adult ¿ Dehydration prevention ¿ Chronic kidney disease ¿ CHF ¿ Recognizing and reporting changes in resident condition (this is completed annually, along with annual review of change in condition policy)	

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F 684	Continued From page 2 decrease her Lasix from 80 mg daily to 40 mg daily. R1's Provider's Order progress note dated 9/24/21, indicated R1 had been seen at urgent care and returned with orders to 1) decrease Lasix to 40 mg daily, 2) decrease lisinopril (blood pressure medication) to 10 mg daily 4) physician to re-evaluate medication in one week. A subsequent note dated 9/24/21 included "Labs indicate that resident was dehydrated and should be encouraged to drink more fluids." R1's physician Order Summary Report dated 9/28/21, included the following: -Daily weight related to heart failure -Encourage fluid intake, every shift for dehydration -Lasix 40 mg one time a day for congestive heart failure -Spironolactone 12.5 mg by mouth one time a day for congestive heart failure. R1's record lacked ongoing consistent edema monitoring after the decrease in diuretic medication and lacked comprehensive fluid intake monitoring and evaluation to determine effectiveness of fluid encouragement intervention. R1's medication administration record (MAR) reviewed from 9/24/21 to 10/10/21 identified the physician order to encourage fluid intake every shift; the record identified the task/order was completed by a checkmark in the corresponding shift box. The documentation did not include frequency, the result of the encouragement, or amount consumed. R1's Point of Care fluid intake documentation was reviewed, the amount of fluid R1 consumed during each meal was identified by	F 684	• Provide education on edema monitoring, dehydration, CHF and fluid balance policy and/or protocols to licensed nurses and TMAs evidence is signature of understanding by 12/3/2021 • Updated nursing admission checklist to ensure activation of CHF and dehydration protocols for new admits and hospital returns • Create order templates for proper monitoring of edema, dehydration, CHF and fluid balance by 12/3/2021. • Completed tracking tool of fluids including pictures and measurements on 11/13/2021. Will distribute and provide education to affected by 12/3/2021. • Facility is exploring options of available assessments and monitoring tools within current EMR (Point Click Care). • Care plans reviewed for residents R1, R2 and R3, updates done if necessary by 12/3/2021. • Audits to be completed weekly x 1 month and then monthly x 3 months to ensure compliance. • Overall compliance to D684 to be completed by 12/3/2021 Compliance for adherence to this plan will be the responsibility of the Director of Nursing with overall compliance being the responsibility of the Administrator.	

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F 684	Continued From page 3	F 684		

percentages of 1-25%, 26-50%, 51 to 75%, or 76-100%. The record did not identify the percentage of the total fluid offered or the total amount of fluid consumed.

R1's weekly progress note dated 9/28/21, indicated R1 did not have edema.

R1's Provider's Order progress note dated 9/29/21, indicated R1 was seen by the physician to address recent medication changes related to hypotension and urgent care visit. The note indicated R1's weights were down, and edema had improved (the record did not identify a date for comparison to reference the improvement from and did not mention an extent of the improvement of the edema). The note also indicated R1's blood pressures remained low, twice daily blood pressure monitoring was implemented, and physician to review next week.

R1's physician visit note dated 10/4/21, indicated reason or visit was for re-evaluation of R1's low blood pressures. The note recapped recent history of emergency room visit for hypotension and dehydration- her lactic acid was elevated "Patient did have acute on chronic kidney injury when seen in the ED." The note also indicated orders to decrease Lasix to 20 mg daily.

R1's physician orders dated 10/4/21, included 1) discontinue Lasix 40 mg, 2) Start Lasix 20 mg every morning related to congestive heart failure.

After R1's order change to further decrease the diuretic medication, R1's record continued to lack edema and fluid intake monitoring and evaluation.

R1's progress note dated 10/4/21, included, "Her

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water pitcher remains full from change over to water pass. Encouraged to drink more water and did take a drink while this nurse was in the room. Wil continue to monitor and push"

R1's progress note dated 10/10/21, indicated R1's family member had reported R1 drank ½ bottle of water.

R1's emergency department discharge summary dated 10/11/21, included diagnoses of acute kidney injury and hypovolemia. The summary included the orders to hold blood pressure medication and Lasix for two days and included "It is very important that you are drinking enough fluid and increasing oral intake over next several days. Drink 4 ounces of fluid every 2 hours while awake (and more if able).

R1's MAR reviewed on and after 10/11/21 identified the hospital order for fluid intake; the MAR included the number of ounces R1 consumed every 2 hours, however all fluid totals consumed were not calculated or evaluated. The record also continued to lack ongoing edema monitoring after the diuretics were put on hold.

R1's social services progress note dated 10/12/21, indicated R1 "was encouraged to drink and dietary was informed she was ready to eat." and "She was offered several options for liquid today and just wanted water."

R1's social services progress note dated 10/13/21, indicated R1 "is drinking fluids".

R1's physician orders dated 10/14/21, directed continued hold on spironolactone and Lasix.

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F 684	Continued From page 5	F 684		

R1's social services progress note dated 10/14/21, included "She is drinking some fluids". A subsequent Provider Order progress note indicated the physician had reviewed labs and R1 "is drinking poorly. Staff have offered multiple options for snacks and beverages but she declines.

R1's weekly summary note dated 10/18/21, indicated R1 did not have edema.

R1's physician orders dated 10/20/21, directed continued hold on spironolactone and Lasix.

During an interview on 10/22/21, at 9:00 a.m. director of nursing (DON) indicated after R1's emergency room visit on 9/24/21, the facility was monitoring for dehydration by offering fluids, holding the medications, and monitoring labs. DON indicated prior to and after to R1's emergency room visit on 9/24/21, fluid intake was recorded in percentages after meals and indicated R1's fluid consumption was not evaluated. DON indicated after her ER visit on 10/11/21, R1 was offered 4 ounces of fluid every 2 hours and the amount was recorded on the MAR and indicated the total daily intake consumed should be documented.

During an interview on 10/22/21, at 2:46 p.m. nursing assistant (NA)-A stated staff encouraged fluids every two hours and would write down the time on a dry erase board by R1's door. NA-A stated we estimate and document how much she drank. NA-A stated the dietary aides and nursing assistance would work together after meals to record the fluids drank in percentages. NA-A stated an unawareness if the total amount of R1 consumed was calculated.

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F 684	Continued From page 6	F 684		

During an interview on 10/22/21, at 3:02 p.m. registered nurse (RN)-A stated nurse or trained medication assistant (TMA) recorded the amount R1 consumed every 2 hours on the MAR. RN-A indicated the amount consumed for meals was documented in percentages. When asked how much total fluid was offered at each meal, RN-A stated she would have to check with dietary staff. RN-A indicated if the amounts were not documented it could not easily be determined how much total fluid was consumed. RN-A indicated if residents had edema, then the nurse should be monitoring and documenting; documentation needs to include specific location and amount. RN-A indicated if the extent of the edema was not described it could not be evaluated for improvement or worsening. RN-A stated descriptive notes were necessary to determine a change or the effectiveness of treatments or medications. RN-A reviewed R1's record, RN-A indicated the record lacked documentation of edema monitoring and consistent assessments. RN-A indicated based on the documentation it could not be determined what impact the reduced and discontinued diuretic medications had on R1's edema or if R1 currently had lower extremity edema.

During an interview on 10/22/21, at 3:23 p.m. medical doctor (MD)-A indicated an expectation nursing be encouraging fluid and record and evaluate fluid volume status and for the effectiveness of treatments.

During an observation and interview on 10/22/21, at 4:09 p.m. R1 sat in a chair in her room, her feet on the floor, and both ankles were observed to be swollen. RN-A asked R1 if she could look at

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F 684	Continued From page 7	F 684		

her legs, R1 consented. RN-A stated R1's left ankle aspects had 2-3+ pitting edema and trace to +1 edema in her foot to mid shin level. RN-A stated R1's right foot had more swelling than the left; R1 had 3-4+ pitting edema in her right ankle aspects and trace-1+ to the foot to mid shin level.

During an interview on 10/22/21, at 4:27 p.m. director of nursing (DON) indicated edema was monitored/assessed dependent upon individual resident, for a stable resident edema was assessed on shower day. DON indicated if there was a change then the physician would be notified, and evaluations would be completed more frequently. DON indicated documentation for edema needed to be descriptive. DON indicated an expectation nursing monitor for signs and symptoms of dehydration daily for residents at risk.

R3
R3's dietary care plan dated 10/28/2015, indicated R3 had a nutritional risk and variable fluid volumes related to fluctuating weight, dependent edema, and diuretic use. The dietary care plan included intervention dated 4/8/2020, to encourage adequate fluid intake on a daily basis. R3's cardiac care plan dated 5/2/2017, included interventions for daily weights and monitor and document any edema, notify physician when appropriate.

R3's quarterly Minimum Data Set (MDS) dated 8/26/21, indicated R3 had intact cognition, required extensive assistance from one staff member for dressing, and was administered diuretic medications.

R3's Physician Order Summary report signed by

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the physician on 10/11/21, included diagnosis of localized edema, venous insufficiency, and chronic kidney disease. The listing included orders for knee high compression socks on in the morning and off at night, weight one time a day related to edema, and Lasix (diuretic medication) 40 milligrams (mg) every morning.

R3's progress note dated 10/11/21, included R3 continued to complain of foot and lower extremity discomfort, presumably related to her edema. This has not responded to using compression or elevation. New orders given to increase Lasix to 60 mg every morning related to congestive heart failure.

R3's record consistently lacked edema monitoring and evaluation of the effectiveness or side effects of the increased dose of Lasix.

R3's progress note dated 10/13/21, indicated R3 had pain in both her feet and chronic joint pain in her hips. The note indicated interventions included diuretics, rest, compression, and elevation. The section of the note that prompted to describe edema, location, and treatment was left blank.

R3's record did not mention edema until 10/20/21. R3's progress note dated 10/20/21, included "chronic BLE [bilateral lower extremity] wears compression stockings daily. The note did not specify the locations of edema on R3's legs, did not evaluate the extent, and did not assess if edema had worsened or improved.

During an interview on 10/22/21, at 3:02 p.m. Registered nurse (RN)-A indicated if residents have edema, then the nurse should be monitoring

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9	F 684		

and documenting; documentation needs to include specific location and amount. RN-A indicated if the extent of the edema was not described it could not be evaluated for improvement or worsening. RN-A stated descriptive notes were necessary to determine a change or the effective of treatments or medications. RN-A reviewed R3's record, RN-A indicated the record lacked documentation of edema monitoring and consistent assessments. RN-A indicated based on the documentation it could not be determined what impact the increased dose of Lasix has had on R3's edema.

During an interview on 10/22/21, at 3:23 p.m. medical doctor (MD)-A indicated an expectation nursing be monitoring and evaluating fluid volume status and for the effectiveness of treatments.

During an observation on 10/22/21, at 3:59 p.m. R3 sat in her wheelchair in her room with her legs in dependent position (down) and had compression socks on. R3's lower extremities were observed to be edematous. RN-A asked R3 to look at her swelling in her legs; R3 consented. RN-A took off R3's socks and shoes, RN-A stated R3 had +4 pitting edema on both her legs from foot to just below the knee. R3 stated that her legs started feeling tired when she walked. R3 indicated the swelling used to go down a little at night, however the last couple of months it seems like they [legs] are worse in the morning than they have been.

During an interview on 10/22/21, at 4:27 p.m. director of nursing (DON) indicated edema was monitored/assessed dependent upon individual resident, for a stable resident edema was assessed on shower day. DON indicated if there

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F 684	Continued From page 10 was a change then the physician would be notified, and evaluations would be completed more frequently. DON indicated documentation for edema needed to be descriptive. Policies were requested and not provided.	F 684		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/22/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5102034C (MN00077571) with a licensing order issued at 0830. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and monitor for fluid overload and/or dehydration for 2 of 3 residents (R1 and R3) reviewed that were administered diuretic medications. Findings include R1's cardiac care plan dated 4/18/2019, identified R1 had altered cardiovascular status related to	2 830	In response to the above stated citation Sauer Health Care took immediate actions: • Meeting with RN Unit Manager and RN MDS Coordinator regarding findings of citation • Reviewed all residents receiving diuretics to ensure proper monitoring is in place if necessary. • Initial investigation was completed by	12/3/21

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2 830	Continued From page 3 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. R1's weekly summary progress note dated 9/20/21 indicated R1 had edema, "BLE [bilateral lower extremity] edema, refuses to wear tubigrip (compression netting used to control swelling), but is a daily weight and takes diuretics. R1's record did not include a comprehensive evaluation of R1's edema. R1's emergency department discharge summary dated 9/24/21, indicated R1 presented to hospital with hypotension and back pain. The summary included "She [R1] does appear to be dehydrated as her lactic acid was elevated and BUN [bun, urea, nitrogen lab test] and creatinine were elevated. We have rehydrated her with 2 L [liter] of IV [intravenous] fluids which she tolerated well." The physician also gave new orders to decrease her Lasix from 80 mg daily to 40 mg daily. R1's Provider's Order progress note dated 9/24/21, indicated R1 had been seen at urgent care and returned with orders to 1) decrease Lasix to 40 mg daily, 2) decrease lisinopril (blood pressure medication) to 10 mg daily 4) physician to re-evaluate medication in one week. A subsequent note dated 9/24/21 included "Labs indicate that resident was dehydrated and should be encouraged to drink more fluids."	2 830	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 1. Edema monitoring 2. Dehydration-Hydration Clinical Protocol 3. CHF-Heart Failure-Clinical Protocol 4. Fluid Balance—Hydration Clinical Protocol Plan to address any future non-compliance. • Health Care Academy courses assigned to Licensed staff and TMA staff to be completed by 12/3/2021 ¿ Nutritional promotion in the older adult ¿ Dehydration prevention ¿ Chronic kidney disease ¿ CHF ¿ Recognizing and reporting changes in resident condition (this is completed annually, along with annual review of change in condition policy) • Provide education on edema monitoring, dehydration, CHF and fluid balance policy and/or protocols to licensed nurses and TMAs evidence is signature of understanding by 12/3/2021 • Updated nursing admission checklist to ensure activation of CHF and dehydration protocols for new admits and hospital returns • Create order templates for proper monitoring of edema, dehydration, CHF and fluid balance by 12/3/2021.	

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2 830	Continued From page 4 R1's physician Order Summary Report dated 9/28/21, included the following: -Daily weight related to heart failure -Encourage fluid intake, every shift for dehydration -Lasix 40 mg one time a day for congestive heart failure -Spironolactone 12.5 mg by mouth one time a day for congestive heart failure. R1's record lacked ongoing consistent edema monitoring after the decrease in diuretic medication and lacked comprehensive fluid intake monitoring and evaluation to determine effectiveness of fluid encouragement intervention. R1's medication administration record (MAR) reviewed from 9/24/21 to 10/10/21 identified the physician order to encourage fluid intake every shift; the record identified the task/order was completed by a checkmark in the corresponding shift box. The documentation did not include frequency, the result of the encouragement, or amount consumed. R1's Point of Care fluid intake documentation was reviewed, the amount of fluid R1 consumed during each meal was identified by percentages of 1-25%, 26-50%, 51 to 75%, or 76-100%. The record did not identify the percentage of the total fluid offered or the total amount of fluid consumed. R1's weekly progress note dated 9/28/21, indicated R1 did not have edema. R1's Provider's Order progress note dated 9/29/21, indicated R1 was seen by the physician to address recent medication changes related to hypotension and urgent care visit. The note indicated R1's weights were down, and edema	2 830	• Completed tracking tool of fluids including pictures and measurements on 11/13/2021. Will distribute and provide education to affected by 12/3/2021. • Facility is exploring options of available assessments and monitoring tools within current EMR (Point Click Care). • Care plans reviewed for residents R1, R2 and R3, updates done if necessary by 12/3/2021. • Audits to be completed weekly x 1 month and then monthly x 3 months to ensure compliance. • Overall compliance to D684 to be completed by 12/3/2021 Compliance for adherence to this plan will be the responsibility of the Director of Nursing with overall compliance being the responsibility of the Administrator.	

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2 830	Continued From page 5	2 830		

had improved (the record did not identify a date for comparison to reference the improvement from and did not mention an extent of the improvement of the edema). The note also indicated R1's blood pressures remained low, twice daily blood pressure monitoring was implemented, and physician to review next week.

R1's physician visit note dated 10/4/21, indicated reason or visit was for re-evaluation of R1's low blood pressures. The note recapped recent history of emergency room visit for hypotension and dehydration- her lactic acid was elevated "Patient did have acute on chronic kidney injury when seen in the ED." The note also indicated orders to decrease Lasix to 20 mg daily.

R1's physician orders dated 10/4/21, included 1) discontinue Lasix 40 mg, 2) Start Lasix 20 mg every morning related to congestive heart failure.

After R1's order change to further decrease the diuretic medication, R1's record continued to lack edema and fluid intake monitoring and evaluation.

R1's progress note dated 10/4/21, included, "Her water pitcher remains full from change over to water pass. Encouraged to drink more water and did take a drink while this nurse was in the room. Wil continue to monitor and push"

R1's progress note dated 10/10/21, indicated R1's family member had reported R1 drank ½ bottle of water.

R1's emergency department discharge summary dated 10/11/21, included diagnoses of acute kidney injury and hypovolemia. The summary included the orders to hold blood pressure medication and Lasix for two days and included

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2 830	Continued From page 6 "It is very important that you are drinking enough fluid and increasing oral intake over next several days. Drink 4 ounces of fluid every 2 hours while awake (and more if able). R1's MAR reviewed on and after 10/11/21 identified the hospital order for fluid intake; the MAR included the number of ounces R1 consumed every 2 hours, however all fluid totals consumed were not calculated or evaluated. The record also continued to lack ongoing edema monitoring after the diuretics were put on hold. R1's social services progress note dated 10/12/21, indicated R1 "was encouraged to drink and dietary was informed she was ready to eat." and "She was offered several options for liquid today and just wanted water." R1's social services progress note dated 10/13/21, indicated R1 "is drinking fluids". R1's physician orders dated 10/14/21, directed continued hold on spironolactone and Lasix. R1's social services progress note dated 10/14/21, included "She is drinking some fluids". A subsequent Provider Order progress note indicated the physician had reviewed labs and R1 "is drinking poorly. Staff have offered multiple options for snacks and beverages but she declines. R1's weekly summary note dated 10/18/21, indicated R1 did not have edema. R1's physician orders dated 10/20/21, directed continued hold on spironolactone and Lasix. During an interview on 10/22/21, at 9:00 a.m.	2 830		

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2 830	Continued From page 7	2 830		

director of nursing (DON) indicated after R1's emergency room visit on 9/24/21, the facility was monitoring for dehydration by offering fluids, holding the medications, and monitoring labs. DON indicated prior to and after to R1's emergency room visit on 9/24/21, fluid intake was recorded in percentages after meals and indicated R1's fluid consumption was not evaluated. DON indicated after her ER visit on 10/11/21, R1 was offered 4 ounces of fluid every 2 hours and the amount was recorded on the MAR and indicated the total daily intake consumed should be documented.

During an interview on 10/22/21, at 2:46 p.m. nursing assistant (NA)-A stated staff encouraged fluids every two hours and would write down the time on a dry erase board by R1's door. NA-A stated we estimate and document how much she drank. NA-A stated the dietary aides and nursing assistance would work together after meals to record the fluids drank in percentages. NA-A stated an unawareness if the total amount of R1 consumed was calculated.

During an interview on 10/22/21, at 3:02 p.m. registered nurse (RN)-A stated nurse or trained medication assistant (TMA) recorded the amount R1 consumed every 2 hours on the MAR. RN-A indicated the amount consumed for meals was documented in percentages. When asked how much total fluid was offered at each meal, RN-A stated she would have to check with dietary staff. RN-A indicated if the amounts were not documented it could not easily be determined how much total fluid was consumed. RN-A indicated if residents had edema, then the nurse should be monitoring and documenting; documentation needs to include specific location and amount. RN-A indicated if the extent of the

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2 830	Continued From page 8	2 830		

edema was not described it could not be evaluated for improvement or worsening. RN-A stated descriptive notes were necessary to determine a change or the effectiveness of treatments or medications. RN-A reviewed R1's record, RN-A indicated the record lacked documentation of edema monitoring and consistent assessments. RN-A indicated based on the documentation it could not be determined what impact the reduced and discontinued diuretic medications had on R1's edema or if R1 currently had lower extremity edema.

During an interview on 10/22/21, at 3:23 p.m. medical doctor (MD)-A indicated an expectation nursing be encouraging fluid and record and evaluate fluid volume status and for the effectiveness of treatments.

During an observation and interview on 10/22/21, at 4:09 p.m. R1 sat in a chair in her room, her feet on the floor, and both ankles were observed to be swollen. RN-A asked R1 if she could look at her legs, R1 consented. RN-A stated R1's left ankle aspects had 2-3+ pitting edema and trace to +1 edema in her foot to mid shin level. RN-A stated R1's right foot had more swelling than the left; R1 had 3-4+ pitting edema in her right ankle aspects and trace-1+ to the foot to mid shin level.

During an interview on 10/22/21, at 4:27 p.m. director of nursing (DON) indicated edema was monitored/assessed dependent upon individual resident, for a stable resident edema was assessed on shower day. DON indicated if there was a change then the physician would be notified, and evaluations would be completed more frequently. DON indicated documentation for edema needed to be descriptive. DON indicated an expectation nursing monitor for signs

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2 830	Continued From page 9 and symptoms of dehydration daily for residents at risk. R3 R3's dietary care plan dated 10/28/2015, indicated R3 had a nutritional risk and variable fluid volumes related to fluctuating weight, dependent edema, and diuretic use. The dietary care plan included intervention dated 4/8/2020, to encourage adequate fluid intake on a daily basis. R3's cardiac care plan dated 5/2/2017, included interventions for daily weights and monitor and document any edema, notify physician when appropriate. R3's quarterly Minimum Data Set (MDS) dated 8/26/21, indicated R3 had intact cognition, required extensive assistance from one staff member for dressing, and was administered diuretic medications. R3's Physician Order Summary report signed by the physician on 10/11/21, included diagnosis of localized edema, venous insufficiency, and chronic kidney disease. The listing included orders for knee high compression socks on in the morning and off at night, weight one time a day related to edema, and Lasix (diuretic medication) 40 milligrams (mg) every morning. R3's progress note dated 10/11/21, included R3 continued to complain of foot and lower extremity discomfort, presumably related to her edema. This has not responded to using compression or elevation. New orders given to increase Lasix to 60 mg every morning related to congestive heart failure. R3's record consistently lacked edema monitoring and evaluation of the effectiveness or side effects	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00705	A. BUILDING: _____ B. WING _____	C 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 10 of the increased dose of Lasix. R3's progress note dated 10/13/21, indicated R3 had pain in both her feet and chronic joint pain in her hips. The note indicated interventions included diuretics, rest, compression, and elevation. The section of the note that prompted to describe edema, location, and treatment was left blank. R3's record did not mention edema until 10/20/21. R3's progress note dated 10/20/21, included "chronic BLE [bilateral lower extremity] wears compression stockings daily. The note did not specify the locations of edema on R3's legs, did not evaluate the extent, and did not assess if edema had worsened or improved. During an interview on 10/22/21, at 3:02 p.m. Registered nurse (RN)-A indicated if residents have edema, then the nurse should be monitoring and documenting; documentation needs to include specific location and amount. RN-A indicated if the extent of the edema was not described it could not be evaluated for improvement or worsening. RN-A stated descriptive notes were necessary to determine a change or the effective of treatments or medications. RN-A reviewed R3's record, RN-A indicated the record lacked documentation of edema monitoring and consistent assessments. RN-A indicated based on the documentation it could not be determined what impact the increased dose of Lasix has had on R3's edema. During an interview on 10/22/21, at 3:23 p.m. medical doctor (MD)-A indicated an expectation nursing be monitoring and evaluating fluid volume status and for the effectiveness of treatments.	2 830		

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2 830	Continued From page 11 During an observation on 10/22/21, at 3:59 p.m. R3 sat in her wheelchair in her room with her legs in dependent position (down) and had compression socks on. R3's lower extremities were observed to be edematous. RN-A asked R3 to look at her swelling in her legs; R3 consented. RN-A took off R3's socks and shoes, RN-A stated R3 had +4 pitting edema on both her legs from foot to just below the knee. R3 stated that her legs started feeling tired when she walked. R3 indicated the swelling used to go down a little at night, however the last couple of months it seems like they [legs] are worse in the morning than they have been. During an interview on 10/22/21, at 4:27 p.m. director of nursing (DON) indicated edema was monitored/assessed dependent upon individual resident, for a stable resident edema was assessed on shower day. DON indicated if there was a change then the physician would be notified, and evaluations would be completed more frequently. DON indicated documentation for edema needed to be descriptive. Policies were requested and not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review/revise facility policies/procedures/guidelines for monitoring and evaluating for fluid balance and management for residents with diagnoses of congestive heart failure or administered diuretic medications. The DON could then re-educate nursing staff on evaluation/assessment/documentation skills for maintaining adequate fluid balance and determining effectiveness of physician ordered treatments. The DON could then develop and implement an auditing system as part of the	2 830		

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2 830	Continued From page 12 facility's quality assurance program. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		