STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245102	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauer Health Care	1635 West Service Drive Winona, MN 55987

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor, and timely notify the physician of a change in condition following a fall for 1 of 3 residents (R2) reviewed for falls, who was receiving anticoagulant (blood thinning) medication and at increased risk for bleeding.Findings include:R2's admission Minimum Data Set (MDS), dated [DATE], indicated moderately impaired cognition with diagnoses including cerebral infarction (stroke), chronic systolic and diastolic heart failure, muscle weakness, unsteadiness on feet, fatigue, abnormalities of gait and mobility, and cognitive communication deficit. The MDS further indicated impaired range of motion to one upper extremity, required partial to moderate assistance with hygiene and dressing, utilized a walker and wheelchair for mobility, had one fall without injury since admission, and was receiving anticoagulant medication. The MDS also indicated a stage 2 pressure injury present on admission.R2's care plan, dated 1/27/26, identified a self-care deficit related to congestive heart failure. Interventions indicated R2 required assistance from one staff member for ambulation with a walker and gait belt, dressing, hygiene, bed mobility, and toileting. The care plan also identified R2 at moderate risk for falls related to gait and balance problems. An intervention dated 2/1/26 included ensuring the call light was within reach, encouraging its use for assistance as needed, and providing prompt response to all requests for help.R2's care plan lacked a focus on anticoagulation management with individualized goals and management of treatment. R2's order summary date 2/2/26 identified to give warfarin (medication that thins the blood) 3 milligram (mg) tablet on Thursday and 4 mg all other days until 2/10/26. R2's Fall report dated 2/4/26 at 7:15 p.m., identified that R2 was up in her recliner when staff arrived for assessment. R2 was not able to remember how she fell and self-reported the fall. The nurse noted that R2 was bleeding from the bottom due to a reopened coccyx wound. Post-fall assessment included evaluation of range of motion (within normal limits), level of pain (0), and mental status (oriented to person), and R2 denied hitting her head. Predisposing factors identified included impaired memory, gait imbalance, and ambulating without assist. Notifications were documented for the POA healthcare/emergency contact, Director of Nursing, Social Services, Administrator, and physician; however, physician notification did not occur at documented time of 8:37 p.m.R2's post-fall follow-up note dated 2/5/26 at 1:49 a.m. identified no new physical findings, no new complaints of pain, stable vital signs, and no new skin issues. Provider did not need to be notified. Lacked neuro assessment.R2's progress note dated 2/5/26 at 2:05 a.m. identified frank blood in the toilet after toileting, observed by nursing assistant (NA). R2 did not report any complaints. Vital signs were taken and documented as stable. The note lacked a neurological assessment, and the provider was not notified of the change in condition.R2's progress note dated 2/5/26 at 5:23 a.m., no blood after toileting this time, likely from skin tear from fall on 2/4/26.R2's transfer progress note dated 2/5/26 at 10:32 a.m. identified that R2 had a fall during the PM shift the night before. R2 had breakthrough bleeding noted on her right gluteal/thigh region. She complained of head pain rated 7/10, was lethargic, and alert and oriented x2, stating she wanted to be assessed by the ED. Vital signs were within normal limits, and pupils were equal, round, and reactive to light. R2 was transferred at 9:20 a.m. via ambulance with two standby assist to the stretcher. At the time of transfer, R2 continued to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complain of right-sided pain, and her level of consciousness remained x2.R2's ED note dated 2/5/26 at 10:37 a.m. identified that she presented following a fall the night before while on blood thinners. R2 was alert and oriented x2 and reported left-sided head pain. She had no weakness. Her INR was elevated at 5.3, indicating a higher risk of bleeding. CT of the head and neck was negative for acute changes. Discharge instructions included close monitoring for falls and adjustment of warfarin dosing.R2's progress note dated 2/5/26 at 5:11 p.m., identified a report from the ED was received by the nurse. R2 had a head and neck CT, which showed no concerns. R2's INR, a blood test that measures how long it takes for blood to clot, was elevated at 5.3 (therapeutic range for most patients on warfarin is typically 2.0-3.0), indicating her blood was too thin. The warfarin order was adjusted.During an interview on 3/19/26 at 1:06 p.m., R2 stated she has had a couple of falls since admission and does not always use her walker or call light when ambulating to the bathroom.During an interview on 3/18/26 at 3:13 p.m., licensed practical nurse (LPN)-A stated she was the nurse working when R2 had a fall on 2/4/26 at 7:15 p.m., resulting in a reopened coccyx wound. Vital signs were within normal limits. LPN-A acknowledged neurological checks were not initiated at the time of the fall and that timely provider notification did not occur due to no on-call physician. Fall interventions included checking on the resident every two hours and providing ADL assistance.During an interview on 3/18/26 at 2:59 p.m., registered nurse (RN)-A verified that R2 had a fall on 2/4/26. The fall resulted in a reopened coccyx wound. Neurological checks were not initiated at the time of the fall, and the provider was not notified. On 2/5/26 at 2:05 a.m., frank blood was noted in the toilet, and no neuro checks were completed or provider notification occurred at that time. R2 later reported head pain of 7/10 and requested transfer to the ED. RN-A sent R2 for a non-emergent transfer to the ED due to concern for a possible brain bleed related to her anticoagulant use and altered cognition.During an interview on 3/19/26 at 10:08 a.m., director of nursing (DON) stated that following an unwitnessed fall, nursing staff are expected to assess for injury, obtain vital signs, initiate neurological checks, notify the provider and family, and document in risk management. Regarding R2's fall on 2/4/26 at 7:15 p.m., the DON confirmed that the fall was self-reported, R2's coccyx wound reopened, and neuro checks were not initiated, though they should have been due to R2's moderate cognitive impairment, anticoagulant use, and the fall being unwitnessed. At 2:05 a.m. on 2/5/26, frank blood was noted in the toilet, and staff did not notify the provider or perform neuro checks at that time. The DON confirmed that a resident on anticoagulants is at increased risk for serious bleeding even with normal vital signs, and that neuro checks are required after any fall, even if no head strike is witnessed. She stated that immediate notification to the provider or transfer to the ED is warranted if a resident on anticoagulants shows signs of bleeding, including frank blood in the toilet, and failure to perform neuro checks or notify the provider could result in an emergent situation.Facility policy titled Change of Condition Awareness, dated 11/26/19, identified the goal was to ensure timely communication of changes in resident condition. The policy directed staff to notify a licensed nurse of any change from baseline, including but not limited to pain, changes in appearance, or increased confusion/lethargy.Facility policy titled Change of Condition Notification, revised 6/1/22, identified nursing staff are responsible to notify the physician of changes in a resident's condition, including accidents/incidents, significant changes in physical condition, and the need for hospital transfer. The policy also directed nurses to assess the resident, gather pertinent information, and document notification and any resulting orders.Facility policy titled Fall Prevention and Management, identified staff are responsible to assess residents for fall risk, implement and monitor interventions, and update the care plan as needed. The policy directed that following a fall, the nurse must assess the resident (including vital signs, level of consciousness, injuries, and pain), initiate neurological assessments for unwitnessed falls or when indicated, notify the physician and interdisciplinary team, complete an incident report, and implement follow-up monitoring and interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to comprehensively assess sling/harness sizes according to manufacturer's instructions to ensure safe transfers for 2 of 2 residents (R4 and R1) who utilized mechanical lifts sit to stand lift and full body mechanical lifts for transfers.Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1's cognition was intact, with diagnoses of cerebral infarction (stroke), hemiparesis (one-sided weakness), hemiplegia (one-sided paralysis), unsteadiness on feet, and need for assist with personal care. Further indicated an impairment in range of motion (ROM) on one side of upper and lower extremities and required substantial to maximal assist for transfers and used a motorized wheelchair for mobility. R4's care plan dated 11/12/20, identified a focus of an activity of daily living (ADL) self-care deficit related to ischemic stroke, left hemiparesis, weakness impaired balance, limited mobility, incontinence, impaired vision, history of falls and potential for pain. An intervention dated 11/12/20 indicated that R4 required extensive assistance from 1-2 staff for transfers using a gait belt and walker, or with a as needed (PRN) EZ Stand lift (brand name of sit-to-stand lift). R1's care plan did not identify the size of the harness required and did not identify if the leg strap was to be utilized for safe transfers using a sit-to-stand mechanical lift. R4's Group Assignment sheet last updated 2/20/26, directed staff that R4 required pivot/) EZ Stand for transfers. R1's assignment sheet did not identify the size of harness R4 required for transfers nor identify if the leg strap was to be used during the transferReview of R4's record identified no documentation of a comprehensive assessment for harness size was completed that would include the resident's weight and circumference of the torso where the harness is applied that is required by the manufacturer for appropriate sizing and safety. Further did not address utilization of the leg strap.R4's fall report dated 2/27/26 at 5:33 p.m., identified that R4 was elevated in an EZ Stand lift with both feet under him and the leg strap not in use. R4 was yelling for help. The writer got behind R4, supported his weight and weak side, and moved his feet in front of him so the aide could safely lower him to the floor. R4 stated, that his foot did not get all the way on the EZ Stand platform. Both feet slipped off because my shoe slipped. Then I was hanging on until you came. R4 was then lifted from the floor to a wheelchair using a Hoyer lift (brand name of a full body mechanical lift). The resident reported soreness to his arm/shoulder but stated it did not feel like anything was broken and later reported it did not get any worse. Does not identify if the leg strap was used.R4's record did not include a comprehensive assessment that would identify the size of sling required for the use of a full body mechanical lift.During an observation and interview on 3/18/26 at 1:47 p.m., R4 was seated in his electric wheelchair and described a prior incident with the EZ Stand lift in his room. R4 stated that during a transfer, a staff member did not position his feet correctly on the platform and failed to use the leg strap, resulting in his legs sliding and becoming trapped underneath him. He reported that his left foot was not on the platform, that's the leg I can't move, and that staff didn't use the strap on the back of my legs. R4 stated the staff member left the room to get help, leaving him hanging, and he was scared while in the lift. A nurse later assisted him safely from the floor.During an interview on 3/18/26 at 2:35 p.m., registered nurse (RN)-A stated that she was working the night of the incident when R4 was hanging in the EZ Stand lift with his feet buckled under him. RN-A reported that R4's left foot had slipped out of his shoe, and both legs were trapped underneath him, and R4 was not strong enough to hold himself up. RN-A got behind R4 and lifted him, repositioning his feet so he could be safely lowered to the floor. She stated that R4 had no injury, only some soreness on his weak side. RN-A noted that the aide said she could have positioned R4's left foot more fully on the platform. RN-A did not believe the leg strap was used during the transfer. RN-A provided coaching and re-education to the aide at that time but did not specifically educate her on using the leg strap, as she had not realized it during the incident.R1's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly Minimum Data Set (MDS) dated [DATE], indicated R1's cognition was intact, with diagnoses of multiple sclerosis, generalized weakness, repeated falls, dependence on wheelchair and need for assist with personal care. Further indicated an impairment in range of motion (ROM) on both sides of lower extremities and was dependent on staff for transfers and used a motorized wheelchair for mobility. R1's care plan dated 7/11/25, identified a focus of self-care deficit related to Multiple Sclerosis. An intervention dated 7/11/25 identified assistance of 2 staff needed with transfers with Hoyer Lift. R1's care plan did not identify the size of sling R1 required for a safe transfer with a full body mechanical lift.Review of R1's record did not include a comprehensive assessment for sling size that identified resident-specific measurements such as height, weight, girth, and the distance from tailbone to base of neck, as required by manufacturer guidelines to ensure proper fit and safety.During an observation and interview on 3/17/26 at 3:37 p.m., R1 was seated in her electric wheelchair in her room. R1 stated that two staff were required to transfer her using a Hoyer lift. R1 was unaware of what sized sling they used for her but assumed the staff should know. R1 stated she was told R4's legs gave out a couple weeks ago when he slid out of his lift.During an interview on 3/18/26 at 2:05 p.m., nursing assistant (NA)-A indicated that sling/harness size was not identified on the care plan or assignment sheet for residents who require mechanical lift transfers. NA-A stated each resident had a sling in their room; however, she was unable to identify the correct size or how to determine appropriate sizing. NA-A reported that if a sling became soiled, she would obtain another from the supply closet but would not know how to select the correct size. NA-A further indicated that use of the EZ stand leg strap was inconsistent among staff, some use the leg strap with the sit to stand lift and others did not. NA-A expressed concerns that the leg strap should be used to prevent a resident's legs from slipping out.During an interview on 3/18/26 at 2:17 p.m., NA-B stated sling and harness sizes were not identified on assignment sheets and she was unsure what size residents required for EZ stand transfers. NA-B reported that while slings were kept in resident rooms, if a sling became soiled, replacements were obtained from the linen room; however, some slings had worn or unreadable tags, making it difficult to determine the correct size. NA-B indicated she would need to ask a nurse for guidance if the size could not be identified.During an interview on 3/18/26 at 2:22 p.m., NA-C indicated that sling/harness size was not identified on the care plan or assignment sheet for residents who required mechanical lift transfers. NA-C performed transfers using an EZ Stand lift but had not received training on use of a leg strap and was unfamiliar with it. NA-C indicated sling or harness sizes were not identified on assignment sheets, and although slings/harnesses were kept in resident rooms, she was unsure how to determine the correct size. NA-C reported that if a sling became soiled, she would not know where to obtain a replacement or how to select the appropriate size without asking staff.During an interview on 3/18/26 at 2:26 p.m., NA-D stated she was unsure how sling or harness sizes were determined for mechanical lift transfers and reported relying on estimation based on resident size or color-coding of straps, although she was not confident in this method. NA-D indicated that sling or harness size was not identified on the Kardex or assignment sheets but stated it should be. NA-D reported she would ask a nurse if unsure of the correct size.During an interview on 3/18/26 at 2:35 p.m., RN-A stated the facility did not complete formal, documented sling or harness size assessments for residents requiring mechanical lifts. Staff generally selected sling sizes based on weight using a reference chart and did not routinely monitor for weight changes that may require size adjustments. RN-A further stated sling or harness size was not documented in the medical record, care plan, or assignment sheet, and nursing assistants must ask nursing staff if unsure which size to use.During an interview on 3/18/26 at 3:53 p.m., the director of nursing (DON) stated the leg strap should always be used with the EZ Stand lift and described R4's incident as a near miss in which the resident's leg slipped during transfer. The DON acknowledged that the facility did not perform formal sling or harness size assessments with mechanical lifts and instead relied on a reference chart based on weight located in the linen room. The DON confirmed sling or harness size was not documented in the care plan and there was no system in place to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor weight changes that may require a different size. The DON indicated nursing staff were expected to determine appropriate sizing; however, no consistent process or documentation existed to ensure safe transfers.During an interview on 3/19/26 at 3:07 p.m., occupational therapist (OT)-A stated the leg strap was essential for safe EZ Stand transfers as it maintains proper positioning and stability, prevents the resident's legs from separating or buckling, and reduces the risk of sliding out of the device, falls, and injury. OT-A indicated residents with weakness, impaired balance, cognitive impairment, or neurological conditions were at higher risk if the leg strap was not used. OT-A further stated safe transfer procedures included verifying the correct lift and properly fitted sling or harness according to manufacturer guidelines. OT-A confirmed that nursing was responsible for determining sling or harness size based on resident-specific measurements and manufacturer recommendations, including weight and body measurements, indicating the importance of an individualized assessment to ensure safe transfers.During a phone interview on 3/19/26 at 2:35 p.m., EZWay lift representative (ELR)-A stated that it was policy to use the leg straps as an extra safety measure to prevent a resident's feet from falling off the platform and increasing the risk of an accident. ELR-A explained that staff should have a system in place to assess harness and sling sizes for mechanical lift use and a way to communicate the appropriate size to staff for safe transfers. ELR-A stated that harness and sling sizes are based on the manufacturer's sizing charts, which are color-coded for each size. Harnesses are determined by the resident's weight and torso circumference where the harness is applied, and slings are determined by weight and the measurement from the bottom of the tailbone to the base of the neck.Facility policy and procedure for mechanical lift equipment and sling/harness assessments was requested and was not received.EZ Way Classic Lift operator's instructions, revised 5/5/25, identified.patient lifts and stands should only be operated by trained personnel, and a full patient assessment should be conducted to determine the appropriate accessory size and type prior to each use.EZ Way Classic Stand operators' instructions revised 4/11/25, identified. The Classic Stand(R) was designed specifically for toileting and changing briefs of patients. The Classic Stand(R) can also be used for transferring the patient from chair, wheelchair, toilet or bed, and can be used for ambulation. As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the Classic Stand(R) is suitable for their needs. Patients should be able to bear some weight, have upper body strength and be able to follow simple commands. If a patient does not meet each of these three criteria, an EZ Way total body lift must be used .patient lifts and stands should only be operated by trained personnel, and a full patient assessment should be conducted to determine the appropriate accessory size and type prior to each use.Ez Way Sling Size Chart, revised 9/13/24, identified a sling color coding system based on weight of patient and maximum distance from patient's tailbone to base of the neck:Small: gray; 70-100 pounds; 21 inchesMedium: beige; 90-220 pounds, 24 inchesLarge: burgundy; 190-320 pounds; 26 inchesExtra-large: green; 280-450 pounds; 26 inchesExtra extra large: 400 -600 pounds; black; 36 inchesExtra extra extra large: brown; 600 + pounds 37 inchesNote: The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit will involve the judgment of the caregiver. It is important to evaluate the width of a patient in relation to the width of the sling. It is important that no portion of the patient overlap the sides of the sling. It is important that the base of the sling be positioned two inches below the tailbone, and the top of the sling is parallel with the top of the shoulder line (base of neck). Note: Slings using Wipeable fabric use beige binding for all sizes and do not follow the color-coding system. Slings using antimicrobial fabric use silver binding for all sizes and do not follow the color-coding system.Ez Way Harness Size Chart, revised 9/13/24, identified a sling color coding system based on weight of patient and circumference of patient's torso where harness is applied:Small: gray; 70-100 pounds; 26 to 38 inchesMedium: beige; 90-220 pounds, 34 to 46 inchesLarge: burgundy; 190-320 pounds; 40 to 56 inchesExtra-large: green; 280-450 pounds; 50 to 64 inchesExtra extra large: 400 -600 pounds; black; 55 to 72 inchesExtra extra extra large: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brown; 600 + pounds; 65 + inchesNote: The size/weight of designations are merely estimates and basic guidelines. A proper fit will involve the judgement of the caregiver. Color coding applies to the binding of the harnesses. Harnesses and accessories using Wipeable fabric use burgundy binding for all sizes and do not follow the color-coding system. Harnesses using antimicrobial fabric use silver binding for all sizes and do not follow the color-coding system.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to identify, assess, and implement an individualized toileting program to maintain or improve bladder continence, for 1 of 1 resident (R2) reviewed for falls.Findings include:R2's admission Minimum Data Set (MDS), dated [DATE], indicated moderately impaired cognition with diagnoses including cerebral infarction (stroke), chronic systolic and diastolic heart failure, muscle weakness, unsteadiness on feet, fatigue, abnormalities of gait and mobility, and cognitive communication deficit. The MDS further indicated impaired range of motion to one upper extremity, required partial to moderate assistance with toileting hygiene and dressing, and utilized a walker and wheelchair for mobility. No trial of a toileting program, including scheduled toileting, prompted voiding, or bladder training, had been attempted on admission despite noted urinary incontinence. R2 had occasional urinary incontinence (less than 7 episodes) and was always continent of bowel. R2 also received diuretics, a medication that can increase urination.R2's record was reviewed and lacked a comprehensive bowel and bladder assessment. R2's Care Area Assessment (CAA), dated 2/3/26, identified R2 was frequently incontinent of urine with modifiable factors such as restricted mobility, underlying conditions including stroke and congestive heart failure, and medications such as diuretics. The CAA did not specify whether R2's incontinence was stress, mixed, transient urge, overflow, or functional. Care plan considerations identified a general objective to avoid complications and improve continence.R2's care plan, dated 1/27/26, identified a self-care deficit related to congestive heart failure. Interventions included R2 required assistance from one staff member for ambulation with a walker and gait belt, dressing, hygiene, bed mobility, and toileting. R2 was frequently incontinent of bladder. R2's care plan did not address urinary incontinence and lacked individualized interventions, including a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training), interventions based on contributing factors such as impaired mobility and cognitive impairment, and monitoring of continence status. The care plan also did not identify the type of incontinence.Review of R2's bladder incontinence record from 3/2/26 to 3/19/26, identified that R2 was continent of urine18 times and incontinent of bladder 15 times. During an observation and interview on 3/19/26 at 12:55 p.m., R2 was observed in her bathroom, with her walker placed next to her recliner. At 1:06 p.m., R2 was seated in her recliner wearing a shirt and a pink pull-up brief, with the walker to the right of her. R2 stated she did not use the call light to request assistance for toileting and reported she walked to the bathroom independently when needed. R2 stated she forgets to use her walker and did not receive assistance from staff for toileting. R2 also reported having episodes of incontinence when attempting to get to the bathroom.During an interview on 3/19/26 at 12:58 p.m., nursing assistant (NA)-E stated R2 was expected to use the call light when she needed assistance; however, staff did not routinely check or offer assistance with toileting. NA-E stated R2 was supposed to use her walker when ambulating but was forgetful and did not always use it.During an interview on 3/18/26 at 3:37 p.m., registered nurse (RN)-A stated the facility did not complete comprehensive bowel and bladder assessments, including three-day assessments, to develop individualized toileting programs. RN-A confirmed R2 was frequently incontinent of bladder and that, although the care plan identified R2 required assistance and was frequently incontinent, no toileting plan or interventions were in place to maintain or improve continence.During an interview on 3/19/26 at 11:15 a.m., director of nursing (DON) stated R2's care plan identified she required one-person assistance with toileting and was frequently incontinent of bladder. The DON confirmed the facility did not complete comprehensive bowel and bladder assessments to develop individualized toileting plans. The DON further confirmed that although R2 was frequently incontinent, no individualized toileting plan or interventions were in place to maintain or improve continence. The DON reported the facility's standard practice was to offer toileting every two hours and confirmed this was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not individualized or reflected in R2's care plan.Facility policy, Urinary Incontinence-Clinical Protocol Policy, revised 4/2/14, identified that upon admission and quarterly, residents are to receive a comprehensive bladder assessment as part of the nursing assessment, with updates to the care plan as needed. The policy requires nursing staff to identify and document circumstances related to incontinence, including frequency and contributing factors. The policy further identifies that the physician will assist in determining the underlying causes and categorizing the type of incontinence. Based on assessment findings, staff are to implement individualized interventions, including scheduled toileting, prompted voiding, or other toileting programs to improve continence. Ongoing monitoring and documentation of the resident's response to interventions is required to determine effectiveness and update the care plan accordingly.

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	245102	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauer Health Care	1635 West Service Drive Winona, MN 55987

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide or arrange emergency care by a doctor 24 hours a day. Based on interview and document review, the facility failed to ensure the provision of 24-hour on-call physician services to respond to 1 of 1 resident (R2) needs, including non-emergent situations that did not require transfer to an alternative setting. This had the potential to affect all 47 residents residing in the facility. Findings include:See F684: R2 who was on blood thinners had a change in condition after a fall (frank blood) and provider was not notified immediately. During an interview on 3/18/26 at 3:13 p.m., licensed practical nurse (LPN)-A indicated she was responsible for R2 when the resident fell on 2/4/26 at 7:15 p.m. R2 was new to the facility and taking blood-thinning medication. The fall caused an existing wound on the resident's bottom to reopen. LPN-A applied a dressing but acknowledged that neurochecks were not performed. She did not notify the provider immediately because the facility did not have an on-call provider; instead, she documented the fall in the communication book for the provider to review during rounds the following day.During an interview on 3/18/26 at 2:59 p.m., registered nurse (RN)-A reported caring for R2 on the morning of 2/5/26. R2 requested to go to the emergency department for a headache rated 7/10. RN-A expressed concern for a possible brain bleed given the fall, blood-thinning medication, and altered cognition. Neurochecks had not been performed after the fall, and the provider was not notified immediately. RN-A confirmed the facility had not had 24-hour on-call physician coverage for the past four years, local providers did not round at the facility or have access to resident medical records, and did not offer on-call coverage.During an interview on 3/19/26 at 10:08 a.m., the director of nursing (DON) stated that after a resident fall, nursing staff are expected to assess for injury, take vital signs, initiate neurochecks, notify the provider, inform the family, and document in risk management. Following R2's fall, neurochecks were not completed despite the resident being on blood-thinning medication and having moderate cognitive impairment. At 2:05 a.m. on 2/5/26, frank blood was noted in the toilet. Staff did not notify the physician immediately, although the DON indicated this should have prompted an ED transfer due to increased risk of bleeding. The DON confirmed that normal vital signs alone were not sufficient to rule out internal bleeding and emphasized that failure to perform neurochecks or notify the provider promptly increases the risk of serious harm.Facility policy, Physician Services, revised 12/23/16, indicated that the facility is responsible for providing or arranging physician services 24 hours a day for emergencies. The policy identified that the primary physician should be contacted first for emergent situations, and if unavailable, the on-call physician should be notified to provide intervention. If the on-call physician does not respond in a timely manner, the medical director is to be contacted. If no physician is reachable and the resident requires immediate assessment, the nurse is to notify the resident's family and transport the resident to the emergency department as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet resident needs for 1 of 1 resident (R4) resulting in a pattern of delayed call light responses and care for R4 Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1's cognition was intact, with diagnoses of cerebral infarction (stroke), hemiparesis (one-sided weakness), hemiplegia (one-sided paralysis), unsteadiness on feet, and need for assist with personal care. Further indicated an impairment in range of motion (ROM) on one side of upper and lower extremities and required substantial to maximal assist for transfers and used a motorized wheelchair for mobility.R4's care plan dated 11/12/20, identified a focus of an activity of daily living (ADL) self-care deficit related to ischemic stroke, left hemiparesis, weakness impaired balance, limited mobility, incontinence, impaired vision, history of falls and potential for pain. An intervention dated 11/12/20 indicated that R4 required extensive assistance from 1-2 staff for transfers using a gait belt and walker, or with a PRN (as needed) EZ Stand lift (brand name of sit-to-stand mechanical lift) During an interview on 3/18/26 at 1:47 p.m., R4 was observed seated in his electric chair and reported that, due to a stroke, he has limited mobility on his left side and required staff assistance for transfers, typically using the EZ Stand lift. R4 stated he had experienced multiple episodes of incontinence related to long call light response times and expressed significant frustration with the delays. He reported that call lights take a good hour to get answered and expressed concern that in a medical emergency, he would not receive timely assistance. R4 stated that he typically used the call light to get in or out of bed or to use the bathroom. R4 described staff response as inconsistent, stating that although staff indicated call lights should be answered within 5-7 minutes, this did not occur in practice. He reported that sometimes call lights were turned off without assistance being provided. R4 noted that while some aides are diligent in providing care, staffing levels were insufficient to meet resident needs. He emphasized his perception that staff did not consistently prioritize resident requests, contributing to delays in assistance.R4's Call light log report was reviewed from 3/5/26 to 3/18/26 (14 days) and identified that R4's call light was active for over 15 minutes on 38 occasions. The longest delays in response primarily occurred in the early morning hours between 5:00 a.m. and 9:00 a.m., with additional prolonged waits observed midday and in the late afternoon to early evening. The average wait time for all call light events were over 15 minutes and approximately 27 minutes and 40 seconds. The longest individual wait times exceeded over 40 minutes on four occasions.R4's Call Light Events with Wait Times Over 15 Minutes:Thursday, 3/5/26:6:41 a.m. to 7:02 a.m., for a total wait time of 21 minutes and 7 seconds.10:24 a.m. to 10:48 a.m., for a total wait time of 24 minutes and 7 seconds.12:23 p.m. to 12:42 p.m., for a total wait time of 18 minutes and 26 seconds.7:30 p.m. to 7:46 p.m., for a total of 16 minutes and 49 seconds. Friday, 3/6/26:6:23 a.m. to 6:42 a.m., for a total of 19 minutes and 57 seconds.9:15 a.m. to 9:32 a.m., for a total wait time of 17 minutes and 15 seconds.12:37 p.m. to 1:15 p.m., for a total wait time of 38 minutes and 19 seconds. Saturday, 3/7/26:9:08 a.m. to 9:37 a.m., for a total wait time of 29 minutes and 15 seconds. Monday, 3/9/26:5:20 a.m. to 5:36 a.m., for a total wait time of 16 minutes 23 seconds.7:24 a.m. to 8:02 a.m., for a total wait time of 37 minutes and 44 seconds.11:28 a.m. to 11:45 a.m., for a total wait time of 17 minutes and 2 seconds.3:15 p.m. to 3:42 p.m., for a total wait time of 26 minutes and 50 seconds. Tuesday, 3/10/26:8:12 a.m. to 9:04 a.m., for a total wait time of 52 minutes and 18 seconds.Wednesday, 3/11/26:5:04 a.m. to 5:32 a.m., for a total wait time of 27 minutes and 23 seconds.8:02 a.m. to 8:37 a.m., for a total wait time of 35 minutes and 38 seconds. Thursday, 3/12/26:5:03 a.m. to 5:46 a.m., for a total wait time of 43 minutes and 28 seconds.7:47 a.m. to 8:10 a.m., for a total wait time of 27 minutes 0 seconds.11:21 a.m. to 11:38 a.m., for a total wait time of 16 minutes 25 seconds.12:23 p.m. to 12:47 p.m., for a total wait time of 23 minutes 49 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seconds.2:57 p.m. to 3:15 p.m., for a total wait time of 17 minutes 48 seconds.6:44 p.m. to 7:00 p.m., for a total wait time of 15 minutes 25 seconds. Friday, 3/13/26:5:19 a.m. to 5:47 a.m., for a total wait time of 28 minutes and 21 seconds.3:28 p.m. to 3:57 p.m., for a total wait time of 29 minutes and 56 seconds.9:09 p.m., to 9:34 p.m., for a total of 25 minutes and 28 seconds. Saturday, 3/14/26:5:55 a.m. to 6:25 a.m., for a total wait time of 29 minutes and 20 seconds. Sunday, 3/15/26:5:09 p.m. to 5:29 p.m., for a total of 20 minutes and 33 seconds. Monday, 3/16/26:8:26 a.m. to 8:51 a.m., for a total wait time of 25 minutes and 59 seconds.9:12 a.m. to 9:54 a.m., for a total wait time of 42 minutes and 37 seconds.12:30 p.m. to 12:53 p.m., for a total wait time of 23 minutes and 47 seconds. Tuesday, 3/17/26:5:16 a.m. to 5:33 a.m., for a total wait time of 17 minutes 58 seconds.9:18 a.m. to 9:49 a.m., for a total wait time of 31 minutes 23 seconds.6:49 p.m. to 7:12 p.m., for a total wait time of 27 minutes 52 seconds. Wednesday, 3/18/26:5:35 a.m. to 6:07 a.m., for a total wait time of 27 minutes and 52 seconds. (bed 1)5:36 a.m. to 6:03 a.m., for a total wait time of 26 minutes and 23 seconds. (bed 2)6:02 a.m., to 6:42 a.m., for a total wait time of 40 minutes 46 seconds. (bed 2).8:24 a.m. to 9:02 a.m., for a total wit time of 38 minutes and 9 seconds (bed 2)11:44 a.m. to 12:11 p.m., for a total wait time of 27 minutes and 22 seconds.4:53 p.m. to 4:21 p.m., for a total wait time of 28 minutes and 23 seconds. During an interview on 3/19/26 at 12:32 p.m., nursing assistant (NA)-F reported that they may not always see or hear call lights if they were in a resident's room. NA-F stated, ideally, calls should be answered within five minutes; however, during busy periods-early mornings around 6:00 a.m., after lunch, and during shift changes-residents may wait up to 30 minutes. NA-F confirmed that R4 most frequently complains about long call light response times. NA-F was unaware that R4 had experienced incontinence due to delayed response times and stated they do their best to respond to all residents promptly.During an interview on 3/19/26 at 12:58 p.m., NA-E reported that she answered R4's call light earlier that day when he wanted to lie down to rest before an activity. NA-E noted that R4 frequently complains about long call light response times and that staff should aim to answer lights within 10 minutes, although this does not always occur.During an interview on 3/19/26 at 10:42 a.m., the Director of Nursing (DON) indicated that R4 was one of the residents who regularly complained of long call light response times. The DON stated that waits over 20 minutes were considered a problem but was unable to specify the expected response time for all residents. She reported that when R4 complained about long wait times, typically exceeding 30 minutes, she reviewed the call light log with him. The DON was unaware that R4 had experienced episodes of incontinence due to delayed response times.Facility policy regarding call light responses was requested and not received.