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	12/19/2024

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 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** 51379 Based on observation, interview and document review, the facility failed to implement appropriate, person-centered interventions to prevent further falls and potential injury for 1 of 1 resident (R20) reviewed for accidents. Findings include: R20's Minimum Data Set (MDS) dated [DATE], indicated R20 was severely cognitively impaired. MDS also indicated R20 had delusional behavior, required two-person physical assist for transferring, position changes, and toileting, required set up only for eating, and bowel and bladder incontinence. R20's medical diagnosis included: dementia with psychotic disturbance and agitation, recurrent urinary tract infection (UTI), disorientation, repeated falls, weakness, lack of coordination, and muscle weakness. R20's care plan dated 3/6/24 indicated R20 had a risk for falls related to gait and balance problem, incontinence, safety unawareness, use of psychotropic medication, and wandering. Further, R20 had a self-care deficit related to dementia and incontinence. During observation on 12/16/24 at 3:01 p.m., R20's room door was shut, upon entering the room, R20 was alone, sitting in her recliner. R20 did not want to answer questions about her care or the facility at this time. Asked to return after dinner. During observation on 12/16/24 at 6:04 p.m., R20's room door was shut, upon entering the room, R20 was alone , sitting in her bed. R20 was not receptive to answering questions. R20 stated she is just too tired today. R20's progress notes dated 9/3/24 at 6:23 a.m., indicated R20 was found sitting on her bottom in the bathroom with feet towards the radiator and head by the sink. Resident reported she fell out of bed and crawled to the bathroom. Fall assessment in this note, R20 was wearing gripper socks at time of fall. Physical assessment was negative for injury; family was notified, updated round book, and email sent to interdisciplinary team (IDT). Intervention at time of fall was to remind resident to use call light for assistance when feeling weak. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's multidisciplinary care conference notes dated 9/4/24 at 9:22 a.m., did not address R20's last fall; additional fall prevention interventions were not implemented. R20's quality review note dated 9/4/24 at 1:46 p.m., care plan was reviewed at this time and no violations occurred along with no injuries. Care plan remained up to date and R20 was given reminders to call for help if she is feeling weak. Provider was updated and provider requested post-fall resident status updates every shift for 24 hours starting on 9/4/24. No further recommendations noted. No resident-specific interventions updated after fall. R20's progress notes dated 10/8/24 at 6:12 p.m., indicated R20 was found sitting on the floor in her room in front of the recliner chair with feet pointed towards wall. Resident reported she was trying to get to recliner so she could take a nap. Fall assessment in this note, R20 was wearing gripper socks at time of fall. Physical assessment was negative for injury; family was notified, updated round book, and email sent to IDT. Interventions at time of fall was to remind resident to use call light for assistance when feeling weak. R20's quality review note dated 10/9/24 at 3:11 p.m., care plan reviewed, and no violations occurred along with no injuries. The care plan remains up to date as this is believed to be an isolated incident. R20 was given reminders to call for help using her call light if she felt weak prior to transfers. Provider was updated and provider requested post-fall resident status updates every shift for 24 hours starting on 10/8/24. No further recommendations noted. No resident-specific interventions updated after fall. R20's progress note dated 11/6/24 at 4:00 p.m., indicated R20 was lying on her left side on the floor parallel to her bed with her feet closer to the door. Facility staff noted her wheelchair was closer to the bathroom door than her bed. Fall assessment was in this note, R20 had been wearing gripper socks at time of fall and call light was within reach but had not been activated by R20. R20 stated at this time she was trying to get into her bed from her wheelchair. Her wheelchair had ended up by her bathroom door while she was by her bed. Physical assessment was negative for injury; family was notified, updated rounds book, and email sent to IDT. R20's quality review note dated 11/8/24 at 9:35 a.m., care plan reviewed at this time and no violations occurred along with no injuries. Care plan was updated to reflect the use of antiroll backs on R20's wheelchair. Provider was updated about fall and agreed with care plan addition of antiroll backs on R20's wheelchair. Provider requested post-fall resident status updates every shift for 24 hours starting on 11/8/24. No further recommendations noted. No resident-specific interventions updated after fall. R20's progress note dated 12/7/24 at 7:07 p.m., indicated R20 turned the wrong way during an assisted transfer and went down to her knees. Head was laying on the bed, did not hit head. Fall assessment was in this note, R20 had been wearing gripper socks at time of fall. Physical assessment was negative for injury; family notified, updated rounds book, and email sent to IDT. No changes or updates done at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's progress note dated 12/8/24 at 8:41 a.m., indicated R20 fell out of her wheelchair to the floor and hit her head. Fall assessment was in this note, R20 was noted to have a large bruise on the right side of her face. R20 assisted back to bed and vital signs taken; were stable. Family notified, updated rounds book, and message sent to provider for additional directions. No changes made to care plan. R20's progress note dated 12/9/24 at 9:45 a.m., indicated the provider had seen a picture of R20's hematoma from the fall; the provider wanted R20 seen in the emergency room (ER) for further evaluation. R20 was sent via ambulance to local ER at 10:00 a.m. R20 had a CT scan while at the ER and this was negative for any acute findings. R20 was sent back to facility at 3:37 p.m. Provider requested post-fall resident status updates every shift for 24 hours starting on 12/8/24. No further recommendations noted. R20's quality review note dated 12/12/24 at 1:31 p.m., care plan reviewed at this time and no violations occurred for either fall. No additional changes made to care plan after falls. No further recommendations from provider after falls. No resident-specific interventions updated after fall. During interview on 12/18/24 at 10:44 a.m., nursing assistant (NA)-A stated R20 had fallen multiple times since admission. NA-A stated she would expect to see a care plan or interventions to include the standard call before you fall sign, correct shoes for ambulation, call light within reach, direct eye supervision, time checks, bed sensors, floor mats, and bed in lowest position for someone like R20 with a history of falls. NA-A confirmed R20 had a care plan in place which included a risk for falls related to gait imbalance, incontinence, safety awareness and psychotropic medications. NA-A confirmed R20 had a call before you fall sign on her closet door, had wheelchair rollbacks, and her call light was within reach. NA-A confirmed these were the generic fall orders all residents have. NA-A verified in the electronic medical record (EMR) R20 did not have resident-specific interventions implemented. During interview on 12/18/24 at 10:52 a.m., registered nurse (RN)-B stated R20 had fallen twice the previous week and R20 has had multiple falls prior to last week. RN-B confirmed R20 had basic falls interventions entered in the care plan. RN-B confirmed R20 had a call before you fall sign on the closet door, wheelchair rollbacks, and her call light within reach. RN-B stated she would have expected interventions such ambulating with proper footwear, specific toileting plan, bed alarms, direct vision, chair sensors, physical therapy consult, and floor mats. RN-B verified in the EMR R20 did not have any person-centered interventions implemented. During interview on 12/18/24 at 11:03 a.m., director of nursing (DON) stated R20 had a history of multiple falls since her initial admission. DON confirmed the facility completed a quality review after each fall. DON confirmed R20 should have resident-specific interventions in place due to high risk for falls. DON confirmed R20 was a risk for falls due to gait and balance problem, incontinence, safety unawareness, use of psychotropic medication, and wandering. DON confirmed R20 had the facility generic fall interventions in place including the call before you fall signage and call light within reach. Based on R20's fall history and quality review, the DON stated she would expect documentation/interventions for a physical therapy consult, direct view of staff, proper footwear, floor mats, supervision with walking, active toileting, and change in condition observations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Sauer Health Care Fall Policy and Procedure dated 4/5/22; the facility will ensure residents live in an environment which is free from hazards over which the facility has control and provide appropriate interventions to each resident to prevent avoidable accidents and injuries. This policy directly states care plans will be updated to reflect the current fall risk/actual fall/fall history, goals, and current interventions. Further, staff will monitor for effectiveness of fall prevention plans and modify approaches to prevent further falls.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42579 Based on observation, interview, and document review, the facility failed to ensure appropriate use of personal protective equipment (PPE) when going from room to room of residents with (R24, R36) and without (R6, R16) COVID-19 positive diagnoses. Findings include: The Center for Disease Control (CDC) Underlying Conditions and the Higher Risk for Severe COVID-19 guidance dated 7/30/24, identified the following high-risk underlying conditions which placed a person at higher risk for severe COVID-19: 1. Age is the strongest risk factor with a 340 times higher risk of death from COVID-19 in those age 85+ and 140 times higher in those ages 75 to 84. 2. High risk medical conditions with a higher risk of death from COVID-19 included asthma, cancer, cardiovascular disease, chronic kidney disease, lung disease, mental health conditions such as depression and neurologic conditions such as dementia. R24's progress note dated 12/8/24 at 3:05 p.m., identified positive for COVID-19. R24's progress note dated 12/17/24 at 10:33 a.m., identified R24 remained on isolation and reported an infrequent cough. During a continuous observation on 12/18/24 from 8:06 a.m., through 8:10 a.m., -At 8:06 a.m. R24's room was identified with posters and a PPE bin as on enhanced respiratory precautions (ERP) with instructions for staff to follow the Centers for Disease Control (CDC) guidelines to wear N95, eye protection, gloves and a gown when entering. Dietary aide (DA)-A brought R24's room tray into her room with an N95 mask on, but no other PPE, set the tray of food on the tray table directly in front of R24, removed the lid covering the food, set to the side, and had a short conversation with the resident. R24 did not have a mask on. While DA-A removed the food tray lid, her scrub top brushed against the room tray table. DA-A exited the room and used alcohol-based hand sanitizer on her hands. R6's diagnosis list dated 12/18/24, identified age 92 and diagnoses of heart failure and pulmonary disease. -At 8:07 a.m., DA-A went directly from R24's room to the food cart and removed a tray, entered R6's room who was not on COVID-19 precautions. DA-A did not change her N95 mask, set the tray on the tray table in front of R6, removed the lid covering the food, had a short conversation with the resident. DA-A exited the room, used alcohol-based hand sanitizer, and did not remove her N95 mask. R36's progress note dated 12/15/24 at 7:55 a.m., identified positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R36's progress note dated 12/17/24 at 18:18 (6:18 p.m.), identified he remained on isolation, had shortness of breath when coughing, dry cough and hoarse voice. -At 8:08 a.m., DA-A went directly from R6's room to the food cart and this time removed gloves from her scrub pants pocket and put them on her hands, took a food tray out of the cart and entered R36's room, which was also identified as having ERP in place for COVID-19. DA-A set the tray on the tray table in front of R36, removed the lid and had a short conversation with the resident. Removed gloves, used alcohol-based hand sanitizer, and exited the room did not change her N95 mask. R16's diagnosis list dated 12/18/24, identified age 79, and diagnoses of stroke, heart disease, depression, and emphysema. -At 8:09 a.m., DA-A went directly from R36's room to the food cart and removed a tray, entered R16's who was not on COVID-19 precautions. DA-A kept the same N95 mask on, set the tray on the tray table in front of R16, removed the lid, had a short conversation with the resident. Used alcohol-based hand sanitizer, exited the room, and did not change her N95 mask. -At 8:10 a.m., registered nurse (RN)-A who was in the hallway at the same time as the dietary staff delivering room trays stated she was not sure if dietary needed to wear full PPE to enter COVID-19 rooms and would need to check with the infection preventionist (IP). -At 8:10 a.m., dietary staff were stopped from delivering trays, when asked, DA-A stated she was not trained to wear full PPE when entering COVID-19 rooms for room tray delivery. Dietary manager (DM) who was also delivering room trays and pushing the cart agreed they did not need to as it was a short time they were in the rooms. The DM stated they delivered room trays to all residents in the facility. During an interview at 8:17 a.m., RN-B stated dietary staff did not need to wear full PPE going into resident rooms with COVID-19 to deliver room trays. During an interview on 12/18/24 at 8:28 a.m., the IP stated all staff have gone through training to don (put on) full PPE when entering the rooms of COVID-19 residents due to risk of touching contaminated items in the resident rooms and transmitting the germs to other locations and people. The facility's COVID-19 Plan and Core Principles of Infection Prevention and Control dated 4/4/24, identified the facility would activate and implement updated guidance based on regulations from local, state, and federal government agencies, including appropriate staff use of PPE. The CDC's Infection Control Guidance dated 6/24/24, identified: this guidance applied to all U.S. settings where healthcare is delivered, all health care personnel (HCP) who enter the room of a patient with suspected or confirmed COVID-19 infection should adhere to standard precautions and use a NIOSH approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).