MINNESOTA
MDH
DEPARTMENT OF HEALTH
Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered
June 22, 2015

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, Minnesota 55387

Subject: Auburn Home In Waconia - IDR
CMS Certification Number (CCN): 24 5583
Project Number S5583023

Dear Mr. Krant:

This is in response to your letter of April 30, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F329 and F428 issued pursuant to the survey event 0K2Y11, completed on April 2, 2015.

The information presented with your letter, the CMS 2567 dated April 2, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F329 S/S- D 42 CFR § 483.25 (1) : Unnecessary Medications
Each resident's drug regimen must be free from unnecessary drugs.

F428 S/S- D 42 CFR § 483.60 (c) Drug Regimen Review
(2) The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

Summary of the facility's reason for IDR of this tag:
The facility disputed the findings based on the fact of the lack of comprehensive discovery of documented medical and resident health care information, incorrect data, and inconsistencies noted in the examples given by the survey team, the facility maintains there was lack of sufficient evidence to support the findings at F329 and F428

Summary of findings:

F329 The facility failed to assess and monitor clinical indications for the continued use of a psychotropic medication for R56 who received Ambien, a sleep aide. A care plan was not developed to identify the resident was on Ambien or non-pharmacological interventions for staff to follow (cited in F279). Because a care plan was not developed to identify non pharmacological interventions and how

to monitor for effectiveness of the medication there was no documentation that was provided to the surveyor to indicate the use of Ambien was effective for the resident. There was no documentation provided to the surveyor to identify the use was discussed in care conferences, interdisciplinary notes, or nursing notes. It is noted that the CAA that was referenced in the 2567 was in error and the most current significant change CAA dated 11/19/2014 indicated the resident was on an antidepressant but did not include the use of a hypnotic. The most recent quarterly MDS dated 2/18/2015 also did not indicate the use of a hypnotic. The sleep log that was provided to the surveyor was dated 10/6/2014 and included sleep monitoring for 3 nights in September (11th, 12th and 13th) and three nights in October (1st, 2nd and 3rd). The indicated the resident was doing well with medications for insomnia and no change however was not signed by facility staff to identify who reviewed the sleep log. There is no indication to determine what medication the resident was taking, what was the prescribed dosage, who reviewed the sleep log and how the information from the sleep log is integrated into the resident's care plan. The DON verified with the surveyor this was the only sleep log that was completed for the resident. Because there was no evidence that staff monitored the continued effectiveness and indications for clinical use of Ambien for R56, this example at F329 will remain valid.

The facility failed to ensure medications had indications for the use of Zantac and omeprazole for R40.

The physician was not able to be reached for an interview during the survey. Additional information was provided by the facility with the IDR from the physician to indicate the resident has struggled with diagnoses related to GERD for several years and currently the symptoms are under excellent control. The combination of the two medications of omeprazole and Zantac was discovered after several months of trial and error with different medications and dosages. The physician has worked with R40 for over five years would recommend not changing the dosage of R40's medications. The indications for use for the medications of omeprazole and Zantac were noted on the March physician orders to be reflux and esophageal. However the facility lacked documentation that R40 was on the two medications and the physician was aware and in support of the two medications. The last physician note that indicated the resident was on both medications for GERD was 8/19/2014. All physician notes moving forward indicated the resident was only on Zantac for GERD. Because the facility did not have documented ongoing communication for the continued use or clear indication of use for either medication of omeprazole or Zantac for R40 the example for R40 at F329 will remain valid.

Further information was provided from the physician in regards to R40's hemoglobin. The hemoglobin had been checked while R40 was in the ER on 4/30/2014 and as recently as 3/5/2015. Both results were in normal ranges (12.2 and 12.5). The pharmacist also indicated that R40's hemoglobin was monitored by the physician. The facility would benefit to have the emergency room records and laboratory work up in the resident's file for future use.

F428 The facility consultant pharmacist failed to identify medication irregularity for indication of use for two medications for R40. In addition the consultant pharmacist failed to monitor hemoglobin level for R40.

Further information was provided during the IDR that identified R40 had her hemoglobin checked 4/30/2014 and as recently as 3/5/2015. Surveyor notes also indicate the consultant pharmacist was aware the physician was monitoring the hemoglobin. This deficient practice example will be removed from the deficiency at F428.

The consultant pharmacist was asked if there was information in regards to R40 being on both Zantac and omeprazole and if there were any recommendations the consultant pharmacist would have. The consultant indicated the information would be in the resident's record. As with the previous deficiency F329 the information was not in the record. The consultant pharmacist should have identified the use of both medications and asked for a clear indication of use. This deficiency remains valid.

These are both valid deficiencies at these tags and at the correct scope and severity of a D.

The removal of the example of the failed monitoring of the hemoglobin level in the based on statement in F428 does not negate the findings in the remainder of the deficiency. The deficiency remains valid at a scope and severity of (D).

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-4135 Fax: 651-281-9796

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gloria Derfus, Metro Team C Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		5/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2015

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 5 residents (R56) who received psychotropic medications. Findings include: On 4/1/15, at 8:50 a.m. R56 was observed seated on her wheel chair in the day room by the nursing station watching television. When approached R56 stated was not feeling well that day and she had vomited the previous night and was hoping to feel better that day. When asked if she was familiar with her medications R56 stated "Yes" when asked if she was having any problems with sleeping, she stated "No, I did not sleep well last night because I had vomited. The doctor explained medications to me why I am taking them." R56's medication and diagnoses included Ambien 5 mg (milligram) at bedtime for insomnia (sleep) dated 6/28/14, Remeron 15 mg at bedtime for depression dated 6/28/14, and Ativan 0.5 mg as needed for anxiety dated 9/16/14, obtained from the Physician Order Report dated 3/1/15. R56's medication regimen review (MRR) sheet revealed the pharmacy consultant had reviewed MRR from 7/18/14, through 2/11/15, however MRR sheet lacked month of March 2015. The consultant pharmacist (CP) recommended on 1/13/15, read, "Periodic review of continued need/benefit is required. If a dose reduction to 2.5 mg is contraindicated, please address. Review with resident's physician during next visit, but no	F 279		

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F 279	Continued From page 2	F 279		

later than two months." However that was not communicated to the doctor until 3/16/15.

During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien and Remeron from 2/1/15, through 3/31/15, except 3/10/15.

R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant. The CAA directed staff to monitor for side effects monthly. The CAA did not indicate R56 received Ambien and Ativan.

During a telephone conversation with the consultant pharmacist (CP) on 4/1/15, at 12:54 p.m. the CP stated, "I was at the facility on 3/17/15, and they did not address my recommendation when I was there in March, I have reviewed everyone but might forget to date [R56] medication regimen review (MRR) sheet. I have the information in my computer. Right now I have no way of getting you the information because I have no fax or electronic device to get you or supply you the information."
- At 1:15 p.m. the director of nursing (DON) verified there was no action taken until 3/16/15, and stated "The expectation is to follow pharmacy recommendation."
- At 1:23 p.m. the DON verified R56 lacked a care plan that addressed R56 ' s use of psychotropic medications she received. At 1:58 p.m. DON stated, "I could not find anything in the care plan specific to Ambien and Remeron."

On 4/2/15, at 8:13 a.m. the DON stated, R56 was

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F 279	Continued From page 3 admitted to the rehabilitation unit with Ambien medication, and then had been moved to long term unit, then admitted to hospice and graduated from hospice when health condition improved. DON further indicated R56 was on Ambien the entire time and added "Her scenario is very different." Auburn Home Psychotropic Medication Use policy and procedure dated 9/14/14, directed, "Auburn Homes and services recognize that psychotropic benefit only some residents and they can be associated with side effects and risks. All residents will be free from unnecessary medications. Therefore, when psychotropic medications are used, target behaviors will be identified and the care plan will be implemented with both non-pharmacological and pharmacological interventions ....." In addition, "..... The pharmacy consultant's recommendation for alterations in the medication regimen including dosage, side effects, potential adverse effects with other medication regimen agents, and adverse reaction symptoms will be received by the director of nursing for follow-up with the appropriate interdisciplinary team (IDT) members." R56's plan of care was not developed for the Amiben and Ativan use.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		5/12/15

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F 282	Continued From page 4 by: Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 1 resident (R29) observed for non-pressure skin conditions and for 1 of 1 hospice resident (R71) who requested a pain medication and did not receive the medication in a timely manner. Findings include: On 3/31/15, at 10:43 a.m. while observing hospice care for R71, a registered nurse (RN)-B entered the room to administer scheduled medications which included Cosopt eye medication solution (to manage eye pressure associated with glaucoma), Flonase nasal spray (for vitamin deficiency) and antipyrine benzocaine (drops to manage disorder and swelling of the ear). When completed, R71 questioned the RN regarding pain medication he had previously requested. RN-B stated she was not aware of the incident but would look into it. -At 11:03 a.m. R71 stated had pain in his chest, shoulders and abdomen. He further explained "I have cancer in my lungs and the pill they give me is a wonder." - At 11:08 a.m. R71's family member (F)-A came into the room She stated she was with her father when he requested the pain pill at the nursing desk located on the Elm unit. She explained the request was made at 10:30 a.m. directly following R71's care conference. F-A then stated she was going to ask the nurse again for the pain medication and left the room. When F-A returned to R71's room at 11:13 a.m. she stated, "I feel it is a problem waiting this long for a pain pill, especially for him." - At 11:14 a.m., a trained medication aide (TMA)-B administered an oxycodone (narcotic	F 282		

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F 282	Continued From page 5 pain medication) 5 milligrams (mg) tablet orally to R71. She explained she was not aware R71 had requested pain medication because she was assigned to the Lake unit from 10:30 through 11:00 a.m. R71's Admission Record, undated, included the following diagnoses of cancer of bronchus/lung, pleural effusion, malaise and fatigue, chest pain, acute pain, and debility. The pain care assessment area (CAA) dated 11/17/14, was triggered due to R71 had complaints of pain and occasional Tylenol (a mild analgesic) use for lung pain that would not improve. R71's pain level was documented as four of ten and made it difficult to sleep and participate in activity. He was able to report his needs. The care plan dated 11/20/14, identified R71 as potential for alteration in comfort related to recent diagnosis of lung cancer and will experience relief of pain. The care plan directed staff to assess discomfort indicators and provide appropriate pain relief measures prn (as needed) following hospice recommendations. The care plan further directed staff to provide pharmacological interventions per medical doctor's orders, evaluate effectiveness, and offer prn analgesics as per MD (medical doctor) order. The Ridgeview Home Care & Hospice correspondence sheet, attention [physician ' s name], described R71 with increased complaints of pain in his shoulders and low back. R71 stated he "needs something stronger for his shoulder and back pain." The correspondence sheet was signed and dated by the Ridgeview Hospice RN	F 282		

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F 282	Continued From page 6 3/24/15. A nursing progress note dated 3/25/15, indicated an order, signed by [physician ' s name] 3/25/15, for Oxycodone Hydrochloride 5 mg every four hours prn, was received by facility. The Medication Administration Record (MAR) verified oxycodone hydrochloride 5 mg was taken from the medication cart on 3/31/15, at 11:10 a.m. for R71" back and side pain. The pain level was recorded as eight of ten, indicating severe pain. The Ridgeview Hospice ACTIVE CARE PLAN (Discipline: Nursing) start of care 3/6/15, stated R71 did not tolerate pain well. On 4/1/15, at 8:25 a.m. RN-B explained she floated between two units, Elm and Island, and functioned as the charge nurse for both. A TMA works with her, passing medication for both units. RN-(B) verified she had received the request for pain medication from RN-D for R71 and passed the information to TMA-B through wireless communicator. On 4/2/15, at 11:47 a.m. the Ridgeview Hospice nurse case manager was interviewed. The hospice RN stated, "I would hope that it would be a quicker response than forty to forty-five minutes, especially if they knew the pain was greater than six of ten. We encourage him (R71) to ask for pain medication at the start of his pain so in doesn't get so severe." - At 11:59 a.m. with the director of nursing (DON) revealed the expectation of receiving a pain medication for pain measuring six of ten or greater would be thirty minutes or sooner. R71	F 282		

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F 282	Continued From page 7 did not receive the pain medication for approximately 45 minutes after the initial request, the staff did not offer the analgesic in a timely manner. R71's plan of care was not followed to have R71 remain pain free and the Ridgeview Hospice ACTIVE CARE PLAN dated 3/6/15, noted R71 did not tolerate pain. R29 had various bruising and discoloration noted to the upper extremities (UE) on 3/31/15, at 10:17 a.m. R29 was not able to explain the origin of the bruises stating she does bruise easily because she takes the medication Coumadin (an anti-coagulant medication to prevent strokes and blood clots, a blood thinner). The initial Skin Condition Assessment dated 1/22/15, identified R29 to have a surgical wound to her left hip, a skin tear to her left elbow, and multiple bruising to bilateral (both sides) UE. The "events" tab in the Point Click Care program of the facility's computer software program lacked any further documentation other than the initial assessment dated 1/25/15. The nursing progress notes, admission to present, failed to identify bruising for R29. The care plan dated 2/10/15, identified R29 at risk for bleeding and bruising related to anticoagulant use, lack of adipose tissue, fragile blood vessels and skin. The care plan directed staff to assess skin for bruising with dressing and bathing and update ADON (assistant director of nursing) and DON if unexplained or excessive. The care plan also instructed staff to conduct a systematic skin inspection on bath day.	F 282		

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F 282	Continued From page 8 During an interview on 4/2/15, at 8:46 a.m. RN-A stated the charge nurse would initiate skin conditions in the "events" tab on the computer and was responsible for measuring, charting and notifying the family. RN-B stated the skin condition would be followed in the Events program in the computer or in the nursing progress notes. She further stated if a resident was admitted with conditions such as bruising and skin tears to be measured and monitored daily by nursing. RN-B explained weekly skin assessments are to be completed by the nursing staff on all residents. The nursing assistants would put on the call light to alert the nurse when they are giving a shower so a body audit may be completed. RN-B stated she had missed several because she had been on break and when she returned the resident had already been dressed. - At 10:34 a.m. RN-A verified nine bruises on the right UE and three bruises on the left UE. RN-A stated that she did not expect bruises due to Coumadin use to be monitored. - At 10:40 a.m. the DON stated she expected all bruises to be measured and monitored regardless of the origin including suspected cause from Coumadin (blood thinner) use as per facility guidelines. She further explained nursing charts skin problems by exception. The DON was unable to explain how the facility determined the cause and origin of a skin condition such as a bruise and how the facility ruled out the possibility of a hematoma (a localized collection of blood outside the blood vessels) The DON could not provide documentation for monitoring bruises or weekly body audits for R29. - At 10:53 a.m. the DON determined R29 had two bruises to her right UE and one bruise to her left anterior (top) hand. The DON further stated she expected these bruises to be identified and	F 282		

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F 282	Continued From page 9 monitored by the nurse. She further explained the facility incorporates primary care and the nurse sees their residents constantly. - At 12:08 p.m. the DON stated she expects staff to do exactly what the care plan says. She would expect a new, unexplained bruise to be reported and assessed by nursing. The Auburn Home in Waconia Policy and Procedure for Skin Assessment revised 4/09, stated: "Every Auburn West resident will be assessed, on a regular basis, for the risk of skin breakdown. If skin breakdown occurs, a procedure will follow to assure ongoing assessments of the wound and effectiveness of the ordered treatment. If a resident is admitted with a skin problem or wound, or develops a skin problem or wound after admission, an RN will assess the wound and initiate a Skin Assessment Flow Sheet.--------and must be implemented to track the progress of the wound and the effectiveness of the treatment ordered. All Nurses Aids will be responsible to report, to the charge nurse, any changes in skin integrity noted during baths, ADL's (activities of Daily Living) or routing cares. Charting on the 'Skin Condition Flow Sheet' should be done to reflect any and all changes. Charting should be done by any nurse at least weekly (daily if the resident is covered by Medicare A.) An RN must assess the progress of the problem or wound least weekly.-------Initial Skin Condition Assessments and Skin Condition Flow Sheets are kept in the Wound Book along with the Treatment Sheets until the problem or would is resolved and then are filed in the resident chart." A policy regarding care planning was requested but not provided.	F 282		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide pain medication in a timely manner for 1 of 1 resident (R71) reviewed for hospice. In addition, the facility did not identify and monitor bruises in 1 of 3 residents (R29) reviewed for non-pressure related skin conditions. Findings Include: R71 pain medication was not given in a timely manner. On 3/31/15, at 10:43 a.m. while observing hospice care for R71, a registered nurse (RN)-B entered the room to administer scheduled medications which included Cosopt eye medication solution (to manage eye pressure associated with glaucoma), Flonase nasal spray (for vitamin deficiency) and antipyrine benzocaine (drops to manage disorder and swelling of the ear). When completed, R71 questioned the RN regarding pain medication he had previously requested. RN-B stated she was not aware of the incident but would look into it. -At 11:03 a.m. R71 stated had pain in his chest,	F 309		5/12/15

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F 309	Continued From page 11 shoulders and abdomen. He further explained "I have cancer in my lungs and the pill they give me is a wonder." - At 11:08 a.m. R71's family member (F)-A came into the room She stated she was with her father when he requested the pain pill at the nursing desk located on the Elm unit. She explained the request was made at 10:30 a.m. directly following R71's care conference. F-A then stated she was going to ask the nurse again for the pain medication and left the room. When F-A returned to R71's room at 11:13 a.m. she stated, "I feel it is a problem waiting this long for a pain pill, especially for him." - At 11:14 a.m. a trained medication aide (TMA)-B administered an oxycodone (narcotic pain medication) 5 milligrams (mg) tablet orally to R71. She explained she was not aware R71 had requested pain medication because she was assigned to the Lake unit from 10:30 through 11:00 a.m. R71's Admission Record, undated, included the following diagnoses of cancer of bronchus/lung, pleural effusion, malaise and fatigue, chest pain, acute pain, and debility. The pain care assessment area (CAA) dated 11/17/14, was triggered due to R71 had complaints of pain and occasional Tylenol (a mild analgesic) use for lung pain that would not improve. R71's pain level was documented as four of ten and made it difficult to sleep and participate in activity. He was able to report his needs. The care plan dated 11/20/14, identified R71 as potential for alteration in comfort related to recent diagnosis of lung cancer and will experience relief	F 309		

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F 309	Continued From page 12 of pain. The care plan directed staff to assess discomfort indicators and provide appropriate pain relief measures prn (as needed) following hospice recommendations. The care plan further directed staff to provide pharmacological interventions per medical doctor's orders, evaluate effectiveness, and offer prn analgesics as per MD (medical doctor) order. The Ridgeview Home Care & Hospice correspondence sheet, attention [physician's name], described R71 with increased complaints of pain in his shoulders and low back. R71 stated he "needs something stronger for his shoulder and back pain." The correspondence sheet was signed and dated by the Ridgeview Hospice RN 3/24/15. A nursing progress note dated 3/25/15, indicated an order, signed by [physician's name] 3/25/15, for Oxycodone Hydrochloride 5 mg every four hours prn, was received by facility. The Medication Administration Record (MAR) verified oxycodone hydrochloride 5 mg was taken from the medication cart on 3/31/15, at 11:10 a.m. for R71" back and side pain. The pain level was recorded as eight of ten, indicating severe pain. The Ridgeview Hospice ACTIVE CARE PLAN (Discipline: Nursing) start of care 3/6/15 states · R71 does not tolerate pain well. On 3/31/15, at 12:12 p.m. RN-D revealed she received the message from R71 and F-A requesting the pain medication after the care conference had ended at approximately 10:30 a.m. and within two to five minutes proceeded to	F 309		

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F 309	Continued From page 13 the Island unit to inform RN-B. On 4/1/15, at 8:25 a.m., RN-B explained she floated between two units, Elm and Island, and functioned as the charge nurse for both. A TMA works with her, passing medication for both units. RN (B) verified she had received the request for pain medication from RN-D for R71 and passed the information to TMA-B through wireless communicator. On 4/2/15, at 11:47 a.m. the Ridgeview Hospice nurse case manager was interviewed. The hospice RN stated, " I would hope that it would be a quicker response than forty to forty-five minutes, especially if they knew the pain was greater than six of ten. We encourage him (R71) to ask for pain medication at the start of his pain so in doesn't get so severe." - At 11:59 a.m. with the director of nursing (DON) revealed the expectation of receiving a pain medication for pain measuring six of ten or greater would be thirty minutes or sooner. R71 did not receive the pain medication for approximately 45 minutes after the initial request, therefore R71 was not provided the necessary services to maintain his ability to be pain free. R29 had Bruises which were not identified and monitored in accordance to facility policy and procedure for skin assessment. On 3/31/15, at 10:17 a.m. various bruising and discoloration was noted to R29's upper extremities (UE). R29 was not able to explain the origin of the bruises stating she does bruise easily because she takes the medication Coumadin (an anti-coagulant medication to	F 309		

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F 309	Continued From page 14 prevent strokes and blood clots, a blood thinner). The initial Skin Condition Assessment dated 1/22/15, identified R29 to have a surgical wound to her left hip, a skin tear to her left elbow, and multiple bruising to bilateral (both sides) UE. The "events" tab in the Point Click Care program of the facility's computer software program lacked any further documentation other than the initial assessment dated 1/25/15. The nursing progress notes, admission to present, failed to identify bruising for R29. The care plan dated 2/10/15, identified R29 at risk for bleeding and bruising related to anticoagulant use, lack of adipose tissue, fragile blood vessels and skin. The care plan directed staff to assess skin for bruising with dressing and bathing and update ADON (assistant director of nursing) and DON if unexplained or excessive. The care plan also instructed staff to conduct a systematic skin inspection on bath day. The April 2015 MAR identified R29 as receiving Coumadin 4 mg two times weekly and 1 mg five times weekly for aftercare, anticoagulation, long-term use. A recheck for the Coumadin level was scheduled on 4/20/15 During an interview on 4/2/15, at 8:46 a.m. RN-A stated the charge nurse would initiate skin conditions in the "events" tab on the computer and was responsible for measuring, charting and notifying the family. RN-B stated the skin condition would be followed in the Events program in the computer or in the nursing progress notes. She further stated if a resident was admitted with conditions such as bruising	F 309		

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F 309	Continued From page 15 and skin tears to be measured and monitored daily by nursing. RN-B explained weekly skin assessments are to be completed by the nursing staff on all residents. The nursing assistants would put on the call light to alert the nurse when they are giving a shower so a body audit may be completed. RN-B stated she had missed several because she had been on break and when she returned the resident had already been dressed. - At 10:34 a.m. RN-A verified nine bruises on the right UE and three bruises on the left UE. RN-A stated that she did not expect bruises due to Coumadin use to be monitored. - At 10:40 a.m. the DON stated she expected all bruises to be measured and monitored regardless of the origin including suspected cause from Coumadin (blood thinner) use as per facility guidelines. She further explained nursing charts skin problems by exception. The DON was unable to explain how the facility determined the cause and origin of a skin condition such as a bruise and how the facility ruled out the possibility of a hematoma (a localized collection of blood outside the blood vessels) The DON could not provide documentation for monitoring bruises or weekly body audits for R29. - At 10:53 a.m. the DON determined R29 had two bruises to her right UE and one bruise to her left anterior (top) hand. The DON further stated she expected these bruises to be identified and monitored by the nurse. She further explained the facility incorporates primary care and the nurse sees their residents constantly. - At 12:08 p.m. the DON stated she expects staff to do exactly what the care plan says. She would expect a new, unexplained bruise to be reported and assessed by nursing. The Auburn Home in Waconia Policy and	F 309		

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F 309	Continued From page 16 Procedure for Skin Assessment revised 4/09 stated: Every Suborn West resident will be assessed, on a regular basis, for the risk of skin breakdown. If skin breakdown occurs, a procedure will follow to assure ongoing assessments of the wound and effectiveness of the ordered treatment. If a resident is admitted with a skin problem or wound, or develops a skin problem or wound after admission, an RN will assess the wound and initiate a Skin Assessment Flow Sheet." In addition, "and must be implemented to track the progress of the wound and the effectiveness of the treatment ordered. All Nurses Aids will be responsible to report, to the charge nurse, any changes in skin integrity noted during baths, ADL's (activities of Daily Living) or routing cares. Charting on the "Skin Condition Flow Sheet" should be done to reflect any and all changes. Charting should be done by any nurse at least weekly (daily if the resident is covered by Medicare A.) An RN must assess the progress of the problem or wound least weekly." In addition, "Initial Skin Condition Assessments and Skin Condition Flow Sheets are kept in the Wound Book along with the Treatment Sheets until the problem or would is resolved and then are filed in the resident chart. A policy regarding care planning was requested but not provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		5/12/15

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F 329	Continued From page 17 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continual use of a psychotropic medication for 1 of 5 residents (R56) who received Ambien (sleep aid). In addition the facility failed to ensure medications had indications for the use of Zantac and omeprazole (used for acid reflux) for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: On 4/1/15, at 8:50 a.m. R56 was observed seated on her wheel chair in the day room by the nursing station watching television. When approached	F 329		

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F 329	Continued From page 18	F 329		

R56 stated was not feeling well that day and she had vomited the previous night and was hoping to feel better that day. When asked if she was familiar with her medications R56 stated "Yes" when asked if she was having any problems with sleeping, she stated "No, I did not sleep well last night because I had vomited. The doctor explained medications to me why I am taking them."

R56's medication and diagnoses included Ambien 5 mg (milligram) at bedtime for insomnia (sleep) dated 6/28/14, Remeron 15 mg at bedtime for depression dated 6/28/14 and Ativan 0.5 mg as needed for anxiety dated 9/16/14 obtained from the Physician Order Report dated 3/1/15.

R56's medication regimen review (MRR) sheet revealed the pharmacy consultant had reviewed MRR from 7/18/14, through 2/11/15, however MRR sheet lacked month of March 2015. The consultant pharmacist (CP) recommended on 1/13/15, read, "periodic review of continued need/benefit is required. If a dose reduction to 2.5 mg was contraindicated, please address. Review with resident's physician during next visit, but no later than two months." However that was not communicated to the doctor until 3/16/15.

During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien, and Remeron from 2/1/15, through 3/31/15, except 3/10/15.

R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. R56's Psychotropic Medication

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F 329	Continued From page 19 Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant. The CAA directed staff to monitor for side effects monthly. The CAA did not indicate R56 received Ambien and Ativan. During a telephone conversation with the CP on 4/1/15, at 12:54 p.m. CP stated, "I was at the facility on 3/17/15 and they did not address my recommendation when I was there in March, I have reviewed everyone but might forget to date [R56] medication regimen review (MRR) sheet. I have the information in my computer. Right now I have no way of getting you the information because I have no fax or electronic device to get you or supply you the information." - At 1:15 p.m. the director of nursing (DON) verified there was no action taken until 3/16/15, and stated "The expectation is to follow pharmacy recommendation." On 4/2/15 at 8:13 a.m. the DON stated, R56 was admitted to the rehabilitation unit with Ambien medication, then had been moved to long tern unit, then admitted to hospice and graduate from hospice when health condition improved. DON further indicated R56 was on Ambien the entire time and added "Her scenario is very different." Auburn Home Psychotropic Medication Use policy and procedure dated 9/14/14, directed, "Auburn Homes and services recognizes that psychotropics benefit only some residents and they can be associated with side effects and risks. All residents will be free from unnecessary medications. Therefore, when psychotropic medications are used, target behaviors will be identified and the care plan will be implemented	F 329		

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F 329	Continued From page 20 with both non-pharmacological and pharmacological interventions ....." In addition, "..... The pharmacy consultant's recommendation for alterations in the medication regimen including dosage, side effects, potential adverse effects with other medication regimen agents, and adverse reaction symptoms will be received by the director of nursing for follow-up with the appropriate interdisciplinary team (IDT) members." On 4/1/15, at 1:15 p.m. R40 was observed seated on her recliner legs elevated covered with a heavy throw blanket. When approached R40 stated she was just resting and taking to nap. When asked if she was cold R40 stated she is always cold but wore a sweater. When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach hurting/heart burn or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn." Nutritional Status Care Area Assessment (CAA) dated 2/26/15, indicated R40 was at moderate nutrition risk related to high Body Mass Index (BMI), excessive nutritionally relevant medication use and over all condition. The CAA did not identify R40 was receiving Zantac and Omeprazole. In addition the CAA did not indicate when a hemoglobin level was last checked and how often it was supposed to be checked. Review of Physician Progress Notes dated 9/19/14, through 3/16/15, lacked evidence of documentation for indication of both medications	F 329		

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F 329	Continued From page 21 and the physician only had indicated R40 was receiving only Zantac for gastroesophageal reflux disease (GERD). R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13. On 4/2/15, at 9:40 a.m. RN-A who was also the unit nurse manager verified there was no recent hemoglobin in R40's chart stated she was going to look in R40's other old chart. When asked if R40 had complaints of stomach being upset RN-A stated "No but she has diverticulosis and sometimes she has diarrhea and is better." RN-A further stated recently R40 had reported heart burn but thought it was related to the stress and had no further complaints after that and no complaints other than that in the past -At 9:45 a.m. RN-A provided a copy of laboratory result which revealed hemoglobin had last been checked 2/12/13, with result of 9.9 (low) grams per deciliter (g/dL) reference ranges (11.8-15.5) - At 11:21 a.m. via telephone spoken with licensed practical nurse who worked with R40's primary physician stated the doctor had her call surveyor and try to answer the questions and if was not able would call back with answers. Surveyor asked what was the indication for using both Prilosec and Zantac at the same time and	F 329		

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F 329	Continued From page 22 what primary physician's recommendation was for checking hemoglobin levels for R40 as last level had been done 2/13/13, yet R40 was receiving the iron supplement twice daily for anemia. Primary physician's nurse indicated she would find out the answers and would call back. - At 12:23 p.m. the DON indicated after looking through orders that R40 had started taking Zantac on 3/17/13, and 3/25/13, for Prilosec. DON also stated after reading through several progress notes in 2013 R40 had reported stomach being upset. When asked what the indication for use was for both medications DON pointed to the physician progress notes and stated "GERD." When asked what the facility expectation was for monitoring hemoglobin level DON stated it was up to the primary physician. DON also verified after going through the three ringer binder which had the consultant pharmacist documentation there was no more documentation regarding indication for both medications as indicated by the CP on the telephone conversation. - At 2:30 p.m. no call back still from primary physician regarding indication for medications use and hemoglobin level monitoring. R40 lacked an indication for receiving both Zantac (Ranitidine) and omeprazole (both used to treat esophageal reflux).	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		5/12/15

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F 428	Continued From page 23 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity for 1 of 5 residents (R40) regarding indication for receiving both Zantac (Ranitidine) and Omeprazole (both used to treat esophageal reflux). Findings inlude: On 4/1/15, at 1:15 p.m. R40 was observed seated on her recliner legs elevated covered with a heavy throw blanket. When approached R40 stated she was just resting and taking to nap. When asked if she was cold R40 stated she is always cold but wore a sweater. When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach hurting/heart burn or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn." During further review of the consultant pharmacist (CP) Monthly Medication Regimen Review it was revealed CP had completed monthly reviews from 7/18/14, through 3/17/15, and "No potential problem or irregularity" had been identified.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

(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 428	Continued From page 24 Nutritional Status Care Area Assessment (CAA) dated 2/26/15, indicated R40 was at moderate nutrition risk related to high Body Mass Index (BMI), excessive nutritionally relevant medication use and over all condition. The CAA did not identify R40 was receiving Zantac and Omeprazole. In addition the CAA did not indicate when a hemoglobin level was last checked and how often it was supposed to be checked. Review of Physician Progress Notes dated 9/19/14, through 3/16/15, lacked evidence of documentation for indication of both medications and the physician only had indicated R40 was receiving only Zantac for gastroesophageal reflux disease (GERD). R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13. On 4/2/15, at 9:40 a.m. RN-A who was also the unit nurse manager verified there was no recent hemoglobin in R40's chart stated she was going to look in R40's other old chart. When asked if R40 had complaints of stomach being upset RN-A stated "No but she has diverticulosis and sometimes she has diarrhea and is better." RN-A further stated recently R40 had reported heart	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

(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 428	Continued From page 25	F 428		

burn but thought it was related to the stress and had no further complaints after that and no complaints other than that in the past
-At 9:45 a.m. RN-A provided a copy of laboratory result which revealed hemoglobin had last been checked 2/12/13, with result of 9.9 (low) grams per deciliter (g/dL) reference ranges (11.8-15.5)
- At 11:21 a.m. via telephone spoken with licensed practical nurse who worked with R40's primary physician stated the doctor had her call surveyor and try to answer the questions and if was not able would call back with answers. Surveyor asked what was the indication for using both Prilosec and Zantac at the same time and what primary physician's recommendation was for checking hemoglobin levels for R40 as last level had been done 2/13/13, yet R40 was receiving the iron supplement twice daily for anemia. Primary physician's nurse indicated she would find out the answers and would call back.
- At 12:10 p.m. the consultant pharmacist was interviewed via telephone when asked what her recommendation was for checking hemoglobin levels for R40 who had a hemoglobin last checked 2/12/13, CP stated "There should be another one in the chart. I know it has been monitored. There is no standard but I would say should be done annually." When asked what her recommendation was for using both Zantac and Prilosec CP stated R40 had a past GI bleed history when asked where the information would be in R40's chart she stated the information was at the facility with all the documentation she had reviewed.
- At 12:23 p.m. the DON indicated after looking through orders that R40 had started taking Zantac on 3/17/13, and 3/25/13, for Prilosec. DON also stated after reading through several progress notes in 2013 R40 had reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

(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 428	Continued From page 26 stomach being upset. When asked what the indication for use was for both medications DON pointed to the physician progress notes and stated "GERD." When asked what the facility expectation was for monitoring hemoglobin level DON stated it was up to the primary physician. DON also verified after going through the three ringer binder which had the consultant pharmacist documentation there was no more documentation regarding indication for both medications as indicated by the CP on the telephone conversation. - At 2:30 p.m. no call back still from primary physician regarding indication for medications use and hemoglobin level monitoring. R40 lacked an indication for receiving both Zantac (Ranitidine) and omeprazole (both used to treat esophageal reflux). The pharmacist did not report the irregularity to the facility.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

(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 431	Continued From page 27 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 4 residents (R2, R71, R85) on Elm household whose medications were observed for medication storage. In addition, the facility did not ensure multiple use vials were dated when opened on Lake and Island households. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R2, R71 and R85, which included eye drops and nasal spray, lacked dates to indicate when they were opened or the medications were expired.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 28 During the medication storage tour on 3/30/15, at 1:39 p.m. with trained medication assistant (TMA)-A, in the Elm household unit medication cart, multiple opened, used, undated and expired medication bottles were observed to be stored. During the tour the following concerns were identified: - R2's artificial tears (Dry eyes) eye drop bottle was opened, used and was undated. - R71's Timolol solution 0.5% (eye drops for glaucoma) bottle was opened, being used and was undated. Cosopt eye drop bottle (used to treat glaucoma) was opened, being used and was undated. Xalatan eye drop bottle (used to treat glaucoma) was opened, being used and was undated. In addition, Fluticosone nasal spray (used to treat non-allergic and allergic rhinitis) bottle was opened and undated. - R85's lubricating eye drop bottle was opened and undated and R85's sodium chloride eye drop bottle was opened and was undated On 3/30/15, at 1:54 p.m. TMA-A verified medications needed to be stored properly, date when opened and discard when expired. At 1:57 p.m. TMA-A stated, the eye drop should have been labeled and would inform the nurse to take corrective actions for storing medications properly. - At 3:49 p.m. registered nurse (RN)-A verified the medications needed to be stored properly, with correct open date. The expired medications needed to be discarded from the medication cart. Further, RN-A stated the nursing staff needed to check expired medications and remove them from the medication carts. RN-A removed the concerned medications from medication cart and stated she will reorder them because she do not know when they were open.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 29 - At 4:03 p.m. the director of nursing (DON) indicated staff was supposed to date medication bottles when opened, check for expired medications, remove expired medications and re-order them from the pharmacy. On 4/1/15, at 12:58 p.m. the consultant pharmacist (CP) stated her expectation was for facility staff should discard expired medications and follow manufacturer recommendation regarding dating eye drops when open. Policy for dating medications dated 8/11, directed, "All insulin, eye, ear and nasal medications will be dated upon opening. If medications are found that have been opened and do not have an opening date, then they will be dated as of the order date listed on the medication." Saint Therese Pharmacy Medications with Accelerated Expiration Dates policy dated 9/2014, directed, "Xalatan discard after 42 days." During medication storage observation on 3/30/15, at 2:30 p.m., an open vial of Tuberculin (a solution used to test for tuberculosis) was observed in the medication cart on the Lake unit. On the vial in hand-written letters was the word "stock". Registered nurse (RN)-C verified it lacked a date when opened and on the package it was stored in. RN-C stated staff was expected to date the vials when opened. RN-C further explained the the Tuberculin solution was used for new residents admitted to the facility in need of a tuberculosis skin test (TST). On 3/30/15, at 12:06 p.m. the DON stated she absolutely expected staff to date Tuberculin solution vials when opened. On 3/30/15, at 3:48 p.m. an open vial of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 30 tuberculin was observed undated on the Island household medication cart. TMA-C verified the vial was opened, undated, and approximately half full. TMA-C stated, "I don't give the injections to the residents, just nurses do." On 4/2/15, at 12:29 p.m. the DON stated the multiple use vials were supposed to be dated by staff when opened.	F 431		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 1, 2015

Mr. Wayne Ward, Interim Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

Re: HFID 00053

Dear Mr. Ward:

This letter acknowledges receipt of your request for an Informal Dispute Resolution (IDR). The IDR request consists of two deficiencies issued at the April 2, 2015 health survey.

It is my understanding that you are contesting the validity of the following:

F329 - D
F428 - D

I have assigned the responsibility for this IDR to Michelle Ness, from the Office of Health Facility Complaint Department. You may contact this supervisor at (651) 201-4217.

Sincerely,

Mary Absolon

Mary Absolon, Program Manager
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone : (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Maria King, Assistant Program Manager
Michelle Ness, Office of Health Facility Complaints (OHFC) Supervisor

IDR acknowledgement for survey 04/02/2015

Auburn
HOMES & SERVICES

May 5, 2015

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900

RE: Project Number S5583023
Addendum

To Whom It May Concern:

Regarding Auburn Home in Waconia formally disputing F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS and F 428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON which was cited as deficient during a standard survey which was completed at the facility on April 2, 2015 by the Minnesota Department of Health, Please consider the following Addendum to the third paragraph of the explanation which states:

'The surveyor also cited at F 329 a consultant pharmacist (CP) recommendation, dated 1/13/15, that was followed-up upon on 3/16/15. The CP 's recommendation follow-up guideline is 2 months following receipt of her recommendations. Given that many months contain 31 days and that the recommendations are typically received by the facility at the end of the clinic business day, the physician follow-up on the recommendation could arguably be timely. Attending physicians have also requested that the CP recommendations be addressed during their 60 day rounds.'

The facility finds it necessary to emphasize that February, 2015 had 28 days. Theoretically, February alone could account for the additional 3 days the citation was based upon, given the other 31 day months of the year.

Thank you for your consideration.

Respectfully Submitted,

Wayne Ward, Administrator

Auburn
HOMES & SERVICES

April 30, 2015

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900

RE: Project Number S5583023

To Whom It May Concern:

Auburn Home in Waconia is formally disputing F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS and F 428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON which was cited as deficient during a standard survey which was completed at the facility on April 2, 2015 by the Minnesota Department of Health. Please consider the following explanation:

F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS and F 428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

Auburn Home in Waconia ensures that the drug regimen of each resident is free from unnecessary drugs. One surveyor noted," During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien, and Remeron from 2/1/15, through 3/31/15, except 3/10/15. R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. According to the surveyor, *R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant. The CAA directed staff to monitor for side effects monthly. The CAA did not indicate R56 received Ambien and Ativan. "The CAA did not indicate R56 received Ambien and Ativan.*

It is important to point out that the CAA the surveyor is referencing does not even exist which creates an environment of ambiguous credibility. The documentation the surveyor is referencing is consistent with R56's Psychotropic Medication CAA dated 11/18/14. Contributing factors to this finding included the fact that Hospice had prescribed these

medications and when the resident 'graduated' from Hospice, the CAA for these medications were not flagged. As a result, R56's plan of care was not developed for the Ambien and Ativan use, although the medications were being tracked on the appropriate medication administration record (MAR).

The surveyor also cited at F 329 a consultant pharmacist (CP) recommendation, dated 1/13/15, that was followed-up upon on 3/16/15. The CP 's recommendation follow-up guideline is 2 months following receipt of her recommendations. Given that many months contain 31 days and that the recommendations are typically received by the facility at the end of the clinic business day, the physician follow-up on the recommendation could arguably be timely. Attending physicians have also requested that the CP recommendations be addressed during their 60 day rounds.

The surveyor continued to document that,*'R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13."*

The surveyor questioned why there was no recent hemoglobin in R40's chart. The director of nursing informed the surveyor that the resident's primary physician develops each individualized resident's lab monitoring regimen.

The surveyor also questioned the use of Zantac and Prilosec (Omeprazole) simultaneously. Evidence-based practice standards supports the use of both H2 blockers and proton pump inhibitors, simultaneously, in patients with severe and/or resilient GERD. The indication for both medications was clearly stated in R40's MAR.

Obviously, R40's medication regimen is effective evidenced by the surveyor's documentation which reads, *'When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach/heart burn or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn."* On 8/19/14, R40's primary physician wrote a progress note (Appendix A/Attachment) which addressed the resident receiving both Omeprazole and Zantac to control her GERD. It reads, *"6. GERD: Scheduled Omeprazole and Zantac." These orders were ordered to be continued for R40's GERD management. The surveyor called R40's primary physician and discussed the cited concerns with the physician's nurse. The surveyor did not receive a*

return phone call from the physician. The facility has contacted R40's primary physician for clarification regarding the resident's medication and lab monitoring regimens. R40's primary physician responded (Appendix A/Attachment) that R40 "has struggled with resistant GERD. Currently her symptoms have been under excellent control on a combination of Omeprazole as well as Zantac. This combination was discovered after several months of trial and error with various dosing and medication. She has done well on both medication." Her physician continues, *"As for her hemoglobin, Rose was seen in the ER on 4/30/14 and on 3/5/15. Hemoglobins were checked at these visits and were normal(12.2 and 12.5). In an effort to simplify the process, I have now requested yearly hemoglobins through Auburn Nursing Home."* Her physician continues, *"At this time, I am medically recommending Rose be continued on her current medication regimen without change."*

Given the lack of comprehensive discovery of documented medical and resident health care information, incorrect data, and inconsistencies, noted in the examples, given by the survey team, the facility maintains that there lacked sufficient evidence to support the citations at F 329 and F 428.

Thank you for your review and consideration. Please contact me with any questions or concerns. I can be reached at 952-361-0318 or at wward@auburnhomes.org.

Respectfully Submitted,

Wayne Ward
Interim Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0K2Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245583**
2.STATE VENDOR OR MEDICAID NO.
(L2) **211027000**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN HOME IN WACONIA**
(L4) **594 CHERRY DRIVE**
(L5) **WACONIA, MN** (L6) **55387**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/02/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/08/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 20, 2015

Mr. Wayne Ward, Administrator
Auburn Home in Waconia
594 Cherry Drive
Waconia, Minnesota 55387

RE: Project Number S5583023

Dear Mr. Ward:

On April 2, 2015, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 12, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 July 2, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

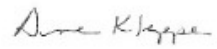
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	**594 CHERRY DRIVE WACONIA, MN 55387**

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		5/12/15

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

Electronically Signed | 04/30/2015

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 5 residents (R56) who received psychotropic medications. Findings include: On 4/1/15, at 8:50 a.m. R56 was observed seated on her wheel chair in the day room by the nursing station watching television. When approached R56 stated was not feeling well that day and she had vomited the previous night and was hoping to feel better that day. When asked if she was familiar with her medications R56 stated "Yes" when asked if she was having any problems with sleeping, she stated "No, I did not sleep well last night because I had vomited. The doctor explained medications to me why I am taking them." R56's medication and diagnoses included Ambien 5 mg (milligram) at bedtime for insomnia (sleep) dated 6/28/14, Remeron 15 mg at bedtime for depression dated 6/28/14, and Ativan 0.5 mg as needed for anxiety dated 9/16/14, obtained from the Physician Order Report dated 3/1/15. R56's medication regimen review (MRR) sheet revealed the pharmacy consultant had reviewed MRR from 7/18/14, through 2/11/15, however MRR sheet lacked month of March 2015. The consultant pharmacist (CP) recommended on 1/13/15, read, "Periodic review of continued need/benefit is required. If a dose reduction to 2.5 mg is contraindicated, please address. Review with resident's physician during next visit, but no	F 279	It is the policy, and intention, of Auburn Home in Waconia to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility□'s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. Auburn Home in Waconia does develop comprehensive care plans for each resident that does include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. One surveyor reported that Resident 56's medication regimen review (MMR) sheet revealed that the pharmacy consultant (CP) had made a recommendation on 1/13/15 that read, "Periodic review of continued need/benefit is required. If a dose reduction to 2.5 g is contraindicated, please address. Review with resident's	

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F 279	Continued From page 2 later than two months." However that was not communicated to the doctor until 3/16/15. During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien and Remeron from 2/1/15, through 3/31/15, except 3/10/15. R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant. The CAA directed staff to monitor for side effects monthly. The CAA did not indicate R56 received Ambien and Ativan. During a telephone conversation with the consultant pharmacist (CP) on 4/1/15, at 12:54 p.m. the CP stated, "I was at the facility on 3/17/15, and they did not address my recommendation when I was there in March, I have reviewed everyone but might forget to date [R56] medication regimen review (MRR) sheet. I have the information in my computer. Right now I have no way of getting you the information because I have no fax or electronic device to get you or supply you the information." - At 1:15 p.m. the director of nursing (DON) verified there was no action taken until 3/16/15, and stated "The expectation is to follow pharmacy recommendation." - At 1:23 p.m. the DON verified R56 lacked a care plan that addressed R56 ' s use of psychotropic medications she received. At 1:58 p.m. DON stated, "I could not find anything in the care plan specific to Ambien and Remeron." On 4/2/15, at 8:13 a.m. the DON stated, R56 was	F 279	physician during the next visit, but no later than two months." The surveyor continued to cite that this recommendation was not communicated to the physician until 3/16/15. Technically, the practice was not deficient in that February only has 28 days and a month typically has 30 to 31 days. That being stated, the communication was timely on 3/16/15. The surveyor noted that R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. According to the surveyor's documentation, R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant and directed staff to monitor for side effects monthly. There is no Psychotropic Medication Use CAA dated 3/19/15 on record for R56. The documentation the surveyor is referencing is actually in a Psychotropic Medication Use CAA dated 11/18/14. According to the surveyor, the CAA did not indicate R56 received Ambien and Ativan. Contributing factors to this finding included the fact that Hospice had prescribed these medications and when the resident 'graduated' from Hospice, the CAA for these medications were not flagged on the CAA. As a result, R56's plan of care was not developed for the Ambien and Ativan use, although the medications were being tracked on the appropriate medication administration record (MAR). There is no specific rule or	

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F 279	Continued From page 3 admitted to the rehabilitation unit with Ambien medication, and then had been moved to long term unit, then admitted to hospice and graduated from hospice when health condition improved. DON further indicated R56 was on Ambien the entire time and added "Her scenario is very different." Auburn Home Psychotropic Medication Use policy and procedure dated 9/14/14, directed, "Auburn Homes and services recognize that psychotropic benefit only some residents and they can be associated with side effects and risks. All residents will be free from unnecessary medications. Therefore, when psychotropic medications are used, target behaviors will be identified and the care plan will be implemented with both non-pharmacological and pharmacological interventions ....." In addition, "..... The pharmacy consultant's recommendation for alterations in the medication regimen including dosage, side effects, potential adverse effects with other medication regimen agents, and adverse reaction symptoms will be received by the director of nursing for follow-up with the appropriate interdisciplinary team (IDT) members." R56's plan of care was not developed for the Amiben and Ativan use.	F 279	regulation that requires these medications to be included in the resident's specific plan of care since they were being monitored on the resident's MAR. In response to the deficiency at F 279, Ambien and Ativan, with identified monitoring, have been added to R56's plan of care. In the spirit of cooperation and optimal resident outcomes, the following responses to this citation have been implemented: Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility licensed nursing staff responsible for MDS, CAA, and care planning completion have completed an MDS basic and intensive re-education module on the Resident Assessment Instrument completion and follow-through hosted through LeadingAge Minnesota. 2. Facility Interdisciplinary Team (IDT) members will review the comprehensive resident assessment protocol as well as communication between outside providers, such as Hospice, communication and appropriate follow-through to ensure continuity of resident care. 3. Ongoing: Quarterly random sample audits of residents care plans for comprehensive inclusion of issues, as well as timely responses to the PC recommendations will occur on a quarterly	

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F 279	Continued From page 4	F 279	basis. Data obtained from this process will be integrated into the quality assurance process and will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 1 resident (R29) observed for non-pressure skin conditions and for 1 of 1 hospice resident (R71) who requested a pain medication and did not receive the medication in a timely manner. Findings include: On 3/31/15, at 10:43 a.m. while observing hospice care for R71, a registered nurse (RN)-B entered the room to administer scheduled medications which included Cosopt eye medication solution (to manage eye pressure associated with glaucoma), Flonase nasal spray (for vitamin deficiency) and antipyrine benzocaine (drops to manage disorder and swelling of the ear). When completed, R71 questioned the RN regarding pain medication he had previously requested. RN-B stated she was not aware of the incident but would look into it.	F 282	Auburn Home in Waconia ensures that the services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. One surveyor noted that on 3/31/15, at 10:43 a.m. while observing hospice care for R71, a registered nurse (RN)-B entered the room to administer scheduled medications which included Cosopt eye medication solution (to manage eye pressure associated with glaucoma), Flonase nasal spray (for vitamin deficiency) and antipyrine benzocaine (drops to manage disorder and swelling of the ear). When completed, R71 questioned the RN regarding pain medication he had previously requested. RN-B stated she was not aware of the incident but would look into it. The	5/12/15

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F 282	Continued From page 5 -At 11:03 a.m. R71 stated had pain in his chest, shoulders and abdomen. He further explained "I have cancer in my lungs and the pill they give me is a wonder." - At 11:08 a.m. R71's family member (F)-A came into the room She stated she was with her father when he requested the pain pill at the nursing desk located on the Elm unit. She explained the request was made at 10:30 a.m. directly following R71's care conference. F-A then stated she was going to ask the nurse again for the pain medication and left the room. When F-A returned to R71's room at 11:13 a.m. she stated, "I feel it is a problem waiting this long for a pain pill, especially for him." - At 11:14 a.m., a trained medication aide (TMA)-B administered an oxycodone (narcotic pain medication) 5 milligrams (mg) tablet orally to R71. She explained she was not aware R71 had requested pain medication because she was assigned to the Lake unit from 10:30 through 11:00 a.m. R71's Admission Record, undated, included the following diagnoses of cancer of bronchus/lung, pleural effusion, malaise and fatigue, chest pain, acute pain, and debility. The pain care assessment area (CAA) dated 11/17/14, was triggered due to R71 had complaints of pain and occasional Tylenol (a mild analgesic) use for lung pain that would not improve. R71's pain level was documented as four of ten and made it difficult to sleep and participate in activity. He was able to report his needs. The care plan dated 11/20/14, identified R71 as potential for alteration in comfort related to recent	F 282	resident had received prescribed Tylenol, 650 mg at 8:30 a.m. according to his pain management protocol. The resident requested additional pain medication following his care conference at 10:30 a.m. The surveyor noted that at 11:14 a.m., a trained medication aide (TMA)-B administered an oxycodone (narcotic pain medication) 5 milligrams (mg) tablet orally to R71. She explained she was not aware R71 had requested pain medication because she was assigned to the Lake unit from 10:30 through 11:00 a.m. The pain care assessment area (CAA) dated 11/17/14, was triggered due to R71's complaints of pain and occasional Tylenol (a mild analgesic) use for lung pain that would not improve. R71's pain level was documented as four of ten and made it difficult to sleep and participate in activity. He was able to report his needs. The care plan dated 11/20/14, identified R71 as potential for alteration in comfort related to recent diagnosis of lung cancer and will experience relief of pain. The care plan directed staff to assess discomfort indicators and provide appropriate pain relief measures prn (as needed) following hospice recommendations. The care plan further directed staff to provide pharmacological interventions per medical doctor's orders, evaluate effectiveness, and offer prn analgesics as per MD (medical doctor) order. The Ridgeview Home Care & Hospice	

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 282	Continued From page 6 diagnosis of lung cancer and will experience relief of pain. The care plan directed staff to assess discomfort indicators and provide appropriate pain relief measures prn (as needed) following hospice recommendations. The care plan further directed staff to provide pharmacological interventions per medical doctor's orders, evaluate effectiveness, and offer prn analgesics as per MD (medical doctor) order. The Ridgeview Home Care & Hospice correspondence sheet, attention [physician ' s name], described R71 with increased complaints of pain in his shoulders and low back. R71 stated he "needs something stronger for his shoulder and back pain." The correspondence sheet was signed and dated by the Ridgeview Hospice RN 3/24/15. A nursing progress note dated 3/25/15, indicated an order, signed by [physician ' s name] 3/25/15, for Oxycodone Hydrochloride 5 mg every four hours prn, was received by facility. The Medication Administration Record (MAR) verified oxycodone hydrochloride 5 mg was taken from the medication cart on 3/31/15, at 11:10 a.m. for R71" back and side pain. The pain level was recorded as eight of ten, indicating severe pain. The Ridgeview Hospice ACTIVE CARE PLAN (Discipline: Nursing) start of care 3/6/15, stated R71 did not tolerate pain well. On 4/1/15, at 8:25 a.m. RN-B explained she floated between two units, Elm and Island, and functioned as the charge nurse for both. A TMA works with her, passing medication for both units.	F 282	correspondence sheet, attention [physician ' s name], described R71 with increased complaints of pain in his shoulders and low back. R71 stated he "needs something stronger for his shoulder and back pain." The correspondence sheet was signed and dated by the Ridgeview Hospice RN 3/24/15. A nursing progress note dated 3/25/15, indicated an order, signed by [physician ' s name] 3/25/15, for Oxycodone Hydrochloride 5 mg every four hours prn, was received by facility. The Medication Administration Record (MAR) verified oxycodone hydrochloride 5 mg was taken from the medication cart on 3/31/15, at 11:10 a.m. for R71" back and side pain. The pain level was recorded as eight of ten, indicating severe pain. The Ridgeview Hospice ACTIVE CARE PLAN (Discipline: Nursing) start of care 3/6/15, stated R71 did not tolerate pain well. In response to the citation at F 282 and upon further analysis, it is apparent that R71 should have had a more aggressive pain management protocol initiated by Hospice. These are contributing factors to this finding. The resident should have had a stronger analgesic, rather than Tylenol, as part of his routine pain management protocol. Once the resident requested the PRN analgesic, his pain was already being reported as a 6/10.	

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F 282	Continued From page 7 RN-(B) verified she had received the request for pain medication from RN-D for R71 and passed the information to TMA-B through wireless communicator. On 4/2/15, at 11:47 a.m. the Ridgeview Hospice nurse case manager was interviewed. The hospice RN stated, "I would hope that it would be a quicker response than forty to forty-five minutes, especially if they knew the pain was greater than six of ten. We encourage him (R71) to ask for pain medication at the start of his pain so in doesn't get so severe." - At 11:59 a.m. with the director of nursing (DON) revealed the expectation of receiving a pain medication for pain measuring six of ten or greater would be thirty minutes or sooner. R71 did not receive the pain medication for approximately 45 minutes after the initial request, the staff did not offer the analgesic in a timely manner. R71's plan of care was not followed to have R71 remain pain free and the Ridgeview Hospice ACTIVE CARE PLAN dated 3/6/15, noted R71 did not tolerate pain. R29 had various bruising and discoloration noted to the upper extremities (UE) on 3/31/15, at 10:17 a.m. R29 was not able to explain the origin of the bruises stating she does bruise easily because she takes the medication Coumadin (an anti-coagulant medication to prevent strokes and blood clots, a blood thinner). The initial Skin Condition Assessment dated 1/22/15, identified R29 to have a surgical wound to her left hip, a skin tear to her left elbow, and multiple bruising to bilateral (both sides) UE.	F 282	Trying to 'get ahead' of the pain at this part is counterintuitive and inconsistent with best practice pain management protocols. In this case, Hospice, not the facility, failed this resident in his pain management protocol. In response to this finding, the facility will initiate dialog with the aforementioned Hospice service regarding pain management protocols to minimize the potential of this isolated finding affecting others. One surveyor cited that R29 had various bruising and discoloration noted to the upper extremities (UE) on 3/31/15, at 10:17 a.m. R29 was not able to explain the origin of the bruises stating she does bruise easily because she takes the medication Coumadin (an anti-coagulant medication to prevent strokes and blood clots, a blood thinner). The surveyor continues to state that the initial Skin Condition Assessment dated 1/22/15, identified R29 to have a surgical wound to her left hip, a skin tear to her left elbow, and multiple bruising to bilateral (both sides) UE. The surveyor also stated that the "events" tab in the Point Click Care program of the facility's computer software program lacked any further documentation other than the initial assessment dated 1/25/15. The nursing progress notes, admission to present, failed to identify bruising for R29. In response to the aforementioned, it should be noted that the facility does not even have the Point Click Care program that was referenced in the surveyor's	

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F 282	Continued From page 8 The "events" tab in the Point Click Care program of the facility's computer software program lacked any further documentation other than the initial assessment dated 1/25/15. The nursing progress notes, admission to present, failed to identify bruising for R29. The care plan dated 2/10/15, identified R29 at risk for bleeding and bruising related to anticoagulant use, lack of adipose tissue, fragile blood vessels and skin. The care plan directed staff to assess skin for bruising with dressing and bathing and update ADON (assistant director of nursing) and DON if unexplained or excessive. The care plan also instructed staff to conduct a systematic skin inspection on bath day. During an interview on 4/2/15, at 8:46 a.m. RN-A stated the charge nurse would initiate skin conditions in the "events" tab on the computer and was responsible for measuring, charting and notifying the family. RN-B stated the skin condition would be followed in the Events program in the computer or in the nursing progress notes. She further stated if a resident was admitted with conditions such as bruising and skin tears to be measured and monitored daily by nursing. RN-B explained weekly skin assessments are to be completed by the nursing staff on all residents. The nursing assistants would put on the call light to alert the nurse when they are giving a shower so a body audit may be completed. RN-B stated she had missed several because she had been on break and when she returned the resident had already been dressed. - At 10:34 a.m. RN-A verified nine bruises on the right UE and three bruises on the left UE. RN-A stated that she did not expect bruises due to Coumadin use to be monitored.	F 282	statement. Additionally, one surveyor had RN-A assess R29's arms in her presence. RN-A, a certified wound nurse, assessed the areas the surveyor had identified as bruises to actually be petechiae consistent with her anticoagulation medication regimen. The surveyor stated twice to the RN-A, "So, those don't look like bruises to you?" Both times, RN-A stated no. This is also inconsistent with the surveyors citation, 'At 10:34 a.m. RN-A verified nine bruises on the right UE and three bruises on the left UE. RN-A stated that she did not expect bruises due to Coumadin use to be monitored.' The director of nursing (DON) accompanied the surveyor to assess R29's arms after RN-A reported her experience to the DON. The resident did have one bruise measuring 2 cm x 2 cm to left anterior hand and two bruises measuring 0.5 cm c 0.5 cm and 1 cm x 2 cm to her right upper extremity. These areas were added to the resident's weekly assessment and documentation tasks. In the spirit of cooperation and optimal resident outcomes, the following responses to this citation have been implemented: Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. The facility will initiate dialog with the aforementioned Hospice service regarding pain management protocols to minimize the potential of this isolated	

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F 282	Continued From page 9 - At 10:40 a.m. the DON stated she expected all bruises to be measured and monitored regardless of the origin including suspected cause from Coumadin (blood thinner) use as per facility guidelines. She further explained nursing charts skin problems by exception. The DON was unable to explain how the facility determined the cause and origin of a skin condition such as a bruise and how the facility ruled out the possibility of a hematoma (a localized collection of blood outside the blood vessels) The DON could not provide documentation for monitoring bruises or weekly body audits for R29. - At 10:53 a.m. the DON determined R29 had two bruises to her right UE and one bruise to her left anterior (top) hand. The DON further stated she expected these bruises to be identified and monitored by the nurse. She further explained the facility incorporates primary care and the nurse sees their residents constantly. - At 12:08 p.m. the DON stated she expects staff to do exactly what the care plan says. She would expect a new, unexplained bruise to be reported and assessed by nursing. The Auburn Home in Waconia Policy and Procedure for Skin Assessment revised 4/09, stated: "Every Auburn West resident will be assessed, on a regular basis, for the risk of skin breakdown. If skin breakdown occurs, a procedure will follow to assure ongoing assessments of the wound and effectiveness of the ordered treatment. If a resident is admitted with a skin problem or wound, or develops a skin problem or wound after admission, an RN will assess the wound and initiate a Skin Assessment Flow Sheet.--------and must be implemented to track the progress of the wound and the effectiveness of the treatment ordered. All Nurses	F 282	finding affecting others. 2. Facility licensed staff will review and discuss best practice strategies for pain control and incorporate them into their professional practice. Weekly skin assessments and supporting documentation will also be reviewed and discussed. Licensed staff will execute the policy and procedure for skin assessments going forward. 3. Ongoing: Quarterly random sample audits of residents' medical records will be conducted to ensure that prn analgesics are given in a timely manner and that routine weekly skin assessments are being conducted. Identified skin conditions should be provided the appropriate intervention as identified by nursing and/or the resident's medical provider. Data obtained from this process will be integrated into the quality assurance process and will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	

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F 282	Continued From page 10 Aids will be responsible to report, to the charge nurse, any changes in skin integrity noted during baths, ADL's (activities of Daily Living) or routing cares. Charting on the 'Skin Condition Flow Sheet' should be done to reflect any and all changes. Charting should be done by any nurse at least weekly (daily if the resident is covered by Medicare A.) An RN must assess the progress of the problem or wound least weekly.-------Initial Skin Condition Assessments and Skin Condition Flow Sheets are kept in the Wound Book along with the Treatment Sheets until the problem or would is resolved and then are filed in the resident chart." A policy regarding care planning was requested but not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide pain medication in a timely manner for 1 of 1 resident (R71) reviewed for hospice. In addition, the facility did not identify and monitor bruises in 1 of 3 residents (R29) reviewed for non-pressure related skin conditions.	F 309	It is the practice of Auburn Home in Waconia to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and individualized plan of	5/12/15

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F 309	Continued From page 11 Findings Include: R71 pain medication was not given in a timely manner. On 3/31/15, at 10:43 a.m. while observing hospice care for R71, a registered nurse (RN)-B entered the room to administer scheduled medications which included Cosopt eye medication solution (to manage eye pressure associated with glaucoma), Flonase nasal spray (for vitamin deficiency) and antipyrine benzocaine (drops to manage disorder and swelling of the ear). When completed, R71 questioned the RN regarding pain medication he had previously requested. RN-B stated she was not aware of the incident but would look into it. -At 11:03 a.m. R71 stated had pain in his chest, shoulders and abdomen. He further explained "I have cancer in my lungs and the pill they give me is a wonder." - At 11:08 a.m. R71's family member (F)-A came into the room She stated she was with her father when he requested the pain pill at the nursing desk located on the Elm unit. She explained the request was made at 10:30 a.m. directly following R71's care conference. F-A then stated she was going to ask the nurse again for the pain medication and left the room. When F-A returned to R71's room at 11:13 a.m. she stated, "I feel it is a problem waiting this long for a pain pill, especially for him." - At 11:14 a.m. a trained medication aide (TMA)-B administered an oxycodone (narcotic pain medication) 5 milligrams (mg) tablet orally to R71. She explained she was not aware R71 had requested pain medication because she was assigned to the Lake unit from 10:30 through	F 309	care. The surveyor's documented findings are duplicative of the findings at F 279. Refer to the facility response at F 279.	

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F 309	Continued From page 12 11:00 a.m. R71's Admission Record, undated, included the following diagnoses of cancer of bronchus/lung, pleural effusion, malaise and fatigue, chest pain, acute pain, and debility. The pain care assessment area (CAA) dated 11/17/14, was triggered due to R71 had complaints of pain and occasional Tylenol (a mild analgesic) use for lung pain that would not improve. R71's pain level was documented as four of ten and made it difficult to sleep and participate in activity. He was able to report his needs. The care plan dated 11/20/14, identified R71 as potential for alteration in comfort related to recent diagnosis of lung cancer and will experience relief of pain. The care plan directed staff to assess discomfort indicators and provide appropriate pain relief measures prn (as needed) following hospice recommendations. The care plan further directed staff to provide pharmacological interventions per medical doctor's orders, evaluate effectiveness, and offer prn analgesics as per MD (medical doctor) order. The Ridgeview Home Care & Hospice correspondence sheet, attention [physician's name], described R71 with increased complaints of pain in his shoulders and low back. R71 stated he "needs something stronger for his shoulder and back pain." The correspondence sheet was signed and dated by the Ridgeview Hospice RN 3/24/15. A nursing progress note dated 3/25/15, indicated an order, signed by [physician's name] 3/25/15,	F 309		

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F 309	Continued From page 13 for Oxycodone Hydrochloride 5 mg every four hours prn, was received by facility. The Medication Administration Record (MAR) verified oxycodone hydrochloride 5 mg was taken from the medication cart on 3/31/15, at 11:10 a.m. for R71" back and side pain. The pain level was recorded as eight of ten, indicating severe pain. The Ridgeview Hospice ACTIVE CARE PLAN (Discipline: Nursing) start of care 3/6/15 states R71 does not tolerate pain well. On 3/31/15, at 12:12 p.m. RN-D revealed she received the message from R71 and F-A requesting the pain medication after the care conference had ended at approximately 10:30 a.m. and within two to five minutes proceeded to the Island unit to inform RN-B. On 4/1/15, at 8:25 a.m., RN-B explained she floated between two units, Elm and Island, and functioned as the charge nurse for both. A TMA works with her, passing medication for both units. RN (B) verified she had received the request for pain medication from RN-D for R71 and passed the information to TMA-B through wireless communicator. On 4/2/15, at 11:47 a.m. the Ridgeview Hospice nurse case manager was interviewed. The hospice RN stated, " I would hope that it would be a quicker response than forty to forty-five minutes, especially if they knew the pain was greater than six of ten. We encourage him (R71) to ask for pain medication at the start of his pain so in doesn't get so severe." - At 11:59 a.m. with the director of nursing (DON)	F 309		

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F 309	Continued From page 14	F 309		

revealed the expectation of receiving a pain medication for pain measuring six of ten or greater would be thirty minutes or sooner. R71 did not receive the pain medication for approximately 45 minutes after the initial request, therefore R71 was not provided the necessary services to maintain his ability to be pain free.

R29 had Bruises which were not identified and monitored in accordance to facility policy and procedure for skin assessment.

On 3/31/15, at 10:17 a.m. various bruising and discoloration was noted to R29's upper extremities (UE). R29 was not able to explain the origin of the bruises stating she does bruise easily because she takes the medication Coumadin (an anti-coagulant medication to prevent strokes and blood clots, a blood thinner).

The initial Skin Condition Assessment dated 1/22/15, identified R29 to have a surgical wound to her left hip, a skin tear to her left elbow, and multiple bruising to bilateral (both sides) UE.

The "events" tab in the Point Click Care program of the facility's computer software program lacked any further documentation other than the initial assessment dated 1/25/15. The nursing progress notes, admission to present, failed to identify bruising for R29.

The care plan dated 2/10/15, identified R29 at risk for bleeding and bruising related to anticoagulant use, lack of adipose tissue, fragile blood vessels and skin. The care plan directed staff to assess skin for bruising with dressing and bathing and update ADON (assistant director of

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F 309	Continued From page 15	F 309		

nursing) and DON if unexplained or excessive. The care plan also instructed staff to conduct a systematic skin inspection on bath day.

The April 2015 MAR identified R29 as receiving Coumadin 4 mg two times weekly and 1 mg five times weekly for aftercare, anticoagulation, long-term use. A recheck for the Coumadin level was scheduled on 4/20/15

During an interview on 4/2/15, at 8:46 a.m. RN-A stated the charge nurse would initiate skin conditions in the "events" tab on the computer and was responsible for measuring, charting and notifying the family. RN-B stated the skin condition would be followed in the Events program in the computer or in the nursing progress notes. She further stated if a resident was admitted with conditions such as bruising and skin tears to be measured and monitored daily by nursing. RN-B explained weekly skin assessments are to be completed by the nursing staff on all residents. The nursing assistants would put on the call light to alert the nurse when they are giving a shower so a body audit may be completed. RN-B stated she had missed several because she had been on break and when she returned the resident had already been dressed.
- At 10:34 a.m. RN-A verified nine bruises on the right UE and three bruises on the left UE. RN-A stated that she did not expect bruises due to Coumadin use to be monitored.
- At 10:40 a.m. the DON stated she expected all bruises to be measured and monitored regardless of the origin including suspected cause from Coumadin (blood thinner) use as per facility guidelines. She further explained nursing charts skin problems by exception. The DON was unable to explain how the facility determined the

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F 309	Continued From page 16 cause and origin of a skin condition such as a bruise and how the facility ruled out the possibility of a hematoma (a localized collection of blood outside the blood vessels) The DON could not provide documentation for monitoring bruises or weekly body audits for R29. - At 10:53 a.m. the DON determined R29 had two bruises to her right UE and one bruise to her left anterior (top) hand. The DON further stated she expected these bruises to be identified and monitored by the nurse. She further explained the facility incorporates primary care and the nurse sees their residents constantly. - At 12:08 p.m. the DON stated she expects staff to do exactly what the care plan says. She would expect a new, unexplained bruise to be reported and assessed by nursing. The Auburn Home in Waconia Policy and Procedure for Skin Assessment revised 4/09 stated: Every Suborn West resident will be assessed, on a regular basis, for the risk of skin breakdown. If skin breakdown occurs, a procedure will follow to assure ongoing assessments of the wound and effectiveness of the ordered treatment. If a resident is admitted with a skin problem or wound, or develops a skin problem or wound after admission, an RN will assess the wound and initiate a Skin Assessment Flow Sheet." In addition, "and must be implemented to track the progress of the wound and the effectiveness of the treatment ordered. All Nurses Aids will be responsible to report, to the charge nurse, any changes in skin integrity noted during baths, ADL's (activities of Daily Living) or routing cares. Charting on the "Skin Condition Flow Sheet" should be done to reflect any and all changes. Charting should be done by any nurse at least weekly (daily if the resident is	F 309		

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F 309	Continued From page 17 covered by Medicare A.) An RN must assess the progress of the problem or wound least weekly." In addition, "Initial Skin Condition Assessments and Skin Condition Flow Sheets are kept in the Wound Book along with the Treatment Sheets until the problem or would is resolved and then are filed in the resident chart. A policy regarding care planning was requested but not provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		5/12/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 329	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continual use of a psychotropic medication for 1 of 5 residents (R56) who received Ambien (sleep aid). In addition the facility failed to ensure medications had indications for the use of Zantac and omeprazole (used for acid reflux) for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: On 4/1/15, at 8:50 a.m. R56 was observed seated on her wheel chair in the day room by the nursing station watching television. When approached R56 stated was not feeling well that day and she had vomited the previous night and was hoping to feel better that day. When asked if she was familiar with her medications R56 stated "Yes" when asked if she was having any problems with sleeping, she stated "No, I did not sleep well last night because I had vomited. The doctor explained medications to me why I am taking them." R56's medication and diagnoses included Ambien 5 mg (milligram) at bedtime for insomnia (sleep) dated 6/28/14, Remeron 15 mg at bedtime for depression dated 6/28/14 and Ativan 0.5 mg as needed for anxiety dated 9/16/14 obtained from the Physician Order Report dated 3/1/15. R56's medication regimen review (MRR) sheet revealed the pharmacy consultant had reviewed MRR from 7/18/14, through 2/11/15, however	F 329	Auburn Home in Waconia ensures that the drug regimen of each resident is free from unnecessary drugs. One surveyor noted," During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien, and Remeron from 2/1/15, through 3/31/15, except 3/10/15. According to the surveyor, R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. According to the surveyor, R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant that the CAA directed staff to monitor for side effects monthly and that the CAA did not indicate R56 received Ambien and Ativan." There is no Psychotropic Medication Use CAA dated 3/16/15 on file for R56. The CAA did not indicate R56 received Ambien and Ativan. Again, it is important to point out that the CAA the surveyor is referencing does not even exist which creates an environment of ambiguous credibility. The documentation the surveyor is referencing is consistent with R56's Psychotropic Medication CAA dated 11/18/14. Contributing factors to this finding included the fact that Hospice had prescribed these medications and when the resident 'graduated' from Hospice, the	

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F 329	Continued From page 19 MRR sheet lacked month of March 2015. The consultant pharmacist (CP) recommended on 1/13/15, read, "periodic review of continued need/benefit is required. If a dose reduction to 2.5 mg was contraindicated, please address. Review with resident's physician during next visit, but no later than two months." However that was not communicated to the doctor until 3/16/15. During further review of R56's medication administration record (MAR) it was revealed R56 had received Ambien, and Remeron from 2/1/15, through 3/31/15, except 3/10/15. R56's quarterly Minimum Data Set (MDS) dated 2/18/15, indicated R56 had intact cognition and received antidepressant medications seven days a week. R56's Psychotropic Medication Use CAA dated 3/19/15, indicated R56 was prescribed an antidepressant. The CAA directed staff to monitor for side effects monthly. The CAA did not indicate R56 received Ambien and Ativan. During a telephone conversation with the CP on 4/1/15, at 12:54 p.m. CP stated, "I was at the facility on 3/17/15 and they did not address my recommendation when I was there in March, I have reviewed everyone but might forget to date [R56] medication regimen review (MRR) sheet. I have the information in my computer. Right now I have no way of getting you the information because I have no fax or electronic device to get you or supply you the information." - At 1:15 p.m. the director of nursing (DON) verified there was no action taken until 3/16/15, and stated "The expectation is to follow pharmacy	F 329	CAA for these medications were not flagged on the CAA. As a result, R56's plan of care was not developed for the Ambien and Ativan use, although the medications were being tracked on the appropriate medication administration record (MAR). In response to the deficiency at F 279, Ambien and Ativan, with identified monitoring, have been added to R56's plan of care. The surveyor also cited at F 329 a CP recommendation, dated 1/13/15, that was followed-up upon on 3/16/15. The CP □s recommendation follow-up guideline is 2 months following receipt of her recommendations. Given that many months contain 31 days and that the recommendations are typically received by the facility at the end of the clinic business day, the physician follow-up on the recommendation could arguably be timely. Attending physicians have also requested that the CP recommendations be addressed during their 60 day rounds. The surveyor continued to document that, 'R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on	

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F 329	Continued From page 20 recommendation." On 4/2/15 at 8:13 a.m. the DON stated, R56 was admitted to the rehabilitation unit with Ambien medication, then had been moved to long tern unit, then admitted to hospice and graduate from hospice when health condition improved. DON further indicated R56 was on Ambien the entire time and added "Her scenario is very different." Auburn Home Psychotropic Medication Use policy and procedure dated 9/14/14, directed, "Auburn Homes and services recognizes that psychotropics benefit only some residents and they can be associated with side effects and risks. All residents will be free from unnecessary medications. Therefore, when psychotropic medications are used, target behaviors will be identified and the care plan will be implemented with both non-pharmacological and pharmacological interventions ....." In addition, "..... The pharmacy consultant's recommendation for alterations in the medication regimen including dosage, side effects, potential adverse effects with other medication regimen agents, and adverse reaction symptoms will be received by the director of nursing for follow-up with the appropriate interdisciplinary team (IDT) members." On 4/1/15, at 1:15 p.m. R40 was observed seated on her recliner legs elevated covered with a heavy throw blanket. When approached R40 stated she was just resting and taking to nap. When asked if she was cold R40 stated she is always cold but wore a sweater. When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach hurting/heart burn	F 329	empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13." The surveyor questioned why there was no recent hemoglobin in R40's chart. The director of nursing informed the surveyor that the resident's primary physician develops each individualized resident's lab monitoring regimen. The surveyor also questioned the use of Zantac and Prilosec (Omeprazole) simultaneously. Evidence-based practice standards supports the use of both H2 blockers and proton pump inhibitors, simultaneously, in patients with severe and/or resilient GERD. The indication for both medications was clearly stated in R40's MAR. Obviously, R40's medication regimen is effective evidenced by the surveyor's documentation which reads, 'When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach/heart burn or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn." On 8/19/14, R40's primary physician wrote a progress note (Appendix A/Attachment) which addressed the resident receiving both Omeprazole and Zantac to control	

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F 329	Continued From page 21 or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn." Nutritional Status Care Area Assessment (CAA) dated 2/26/15, indicated R40 was at moderate nutrition risk related to high Body Mass Index (BMI), excessive nutritionally relevant medication use and over all condition. The CAA did not identify R40 was receiving Zantac and Omeprazole. In addition the CAA did not indicate when a hemoglobin level was last checked and how often it was supposed to be checked. Review of Physician Progress Notes dated 9/19/14, through 3/16/15, lacked evidence of documentation for indication of both medications and the physician only had indicated R40 was receiving only Zantac for gastroesophageal reflux disease (GERD). R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13. On 4/2/15, at 9:40 a.m. RN-A who was also the unit nurse manager verified there was no recent hemoglobin in R40's chart stated she was going	F 329	her GERD. It reads, "6. GERD: Scheduled Omeprazole and Zantac." These orders were ordered to be continued for R40's GERD management. The surveyor called R40's primary physician and discussed the cited concerns with the physician's nurse. The surveyor did not receive a return phone call from the physician. The facility has contacted R40's primary physician for clarification regarding the resident's medication and lab monitoring regimens. R40's primary physician responded (Appendix A/Attachment) that R40 "has struggled with resistant GERD. Currently her symptoms have been under excellent control on a combination of Omeprazole as well as Zantac. This combination was discovered after several months of trial and error with various dosing and medication. She has done well on both medication." Her physician continues, "As for her hemoglobin, Rose was seen in the ER on 4/30/14 and on 3/5/15. Hemoglobins were checked at these visits and were normal (12.2 and 12.5). In an effort to simplify the process, I have now requested yearly hemoglobins through Auburn Nursing Home." Her physician continues, "At this time, I am medically recommending Rose be continued on her current medication regimen without change."	

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F 329	Continued From page 22 to look in R40's other old chart. When asked if R40 had complaints of stomach being upset RN-A stated "No but she has diverticulosis and sometimes she has diarrhea and is better." RN-A further stated recently R40 had reported heart burn but thought it was related to the stress and had no further complaints after that and no complaints other than that in the past -At 9:45 a.m. RN-A provided a copy of laboratory result which revealed hemoglobin had last been checked 2/12/13, with result of 9.9 (low) grams per deciliter (g/dL) reference ranges (11.8-15.5) - At 11:21 a.m. via telephone spoken with licensed practical nurse who worked with R40's primary physician stated the doctor had her call surveyor and try to answer the questions and if was not able would call back with answers. Surveyor asked what was the indication for using both Prilosec and Zantac at the same time and what primary physician's recommendation was for checking hemoglobin levels for R40 as last level had been done 2/13/13, yet R40 was receiving the iron supplement twice daily for anemia. Primary physician's nurse indicated she would find out the answers and would call back. - At 12:23 p.m. the DON indicated after looking through orders that R40 had started taking Zantac on 3/17/13, and 3/25/13, for Prilosec. DON also stated after reading through several progress notes in 2013 R40 had reported stomach being upset. When asked what the indication for use was for both medications DON pointed to the physician progress notes and stated "GERD." When asked what the facility expectation was for monitoring hemoglobin level DON stated it was up to the primary physician. DON also verified after going through the three ringer binder which had the consultant pharmacist documentation there was no more documentation	F 329	It is the position of the facility that there were no deficient practices related to the facility at this citation. It is the facility's intent to submit an Informal Dispute Resolution request. In the spirit of cooperation and optimal resident outcomes, the following responses to this citation have been implemented: Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility licensed staff will review and discuss best practice strategies for medication and lab work monitoring practice protocols, consistent with professional and standards of nursing practice. Facility staff will be instructed to report irregularities in monitoring or therapeutic practices to their supervisor or physician for follow through. 2. The CP will continue medication regimen reviews with monthly communication with the DON to ensure timely responses to the CP's recommendations by all identified parties. 3. Ongoing: Quarterly random sample audits of residents' medical records will be conducted to ensure that medication and lab work monitoring practices are consistent with the facility's protocols and standards of professional and standards of nursing practice. Data obtained from this process will be integrated into the	

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F 329	Continued From page 23 regarding indication for both medications as indicated by the CP on the telephone conversation. - At 2:30 p.m. no call back still from primary physician regarding indication for medications use and hemoglobin level monitoring. R40 lacked an indication for receiving both Zantac (Ranitidine) and omeprazole (both used to treat esophageal reflux). In addition, the facility failed to monitor hemoglobin level for R40 who received Ferrous Gluconate (an Iron supplement).	F 329	quality assurance process and will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity for 1 of 5 residents (R40) regarding indication for receiving both Zantac (Ranitidine) and Omeprazole (both used to treat esophageal reflux). In addition failed to monitor hemoglobin level for R40 who received Ferrous Gluconate (an Iron supplement) reviewed	F 428	Auburn Home in Waconia ensures that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and that the pharmacist reports any irregularities to the attending physician, and the director of nursing and these reports are acted upon.	5/12/15

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F 428	Continued From page 24 for unnecessary medications. Findings inlude: On 4/1/15, at 1:15 p.m. R40 was observed seated on her recliner legs elevated covered with a heavy throw blanket. When approached R40 stated she was just resting and taking to nap. When asked if she was cold R40 stated she is always cold but wore a sweater. When asked if she was familiar with her medications R40 stated "No I don't know" when asked if she was having any problems with her stomach hurting/heart burn or having trouble after eating R40 stated "No I feel very well have not had the pain for a while. I usually have a slice of toast with some juice and coffee in the morning. At times I have diarrhea or nausea but not heart burn." During further review of the consultant pharmacist (CP) Monthly Medication Regimen Review it was revealed CP had completed monthly reviews from 7/18/14, through 3/17/15, and "No potential problem or irregularity" had been identified. Nutritional Status Care Area Assessment (CAA) dated 2/26/15, indicated R40 was at moderate nutrition risk related to high Body Mass Index (BMI), excessive nutritionally relevant medication use and over all condition. The CAA did not identify R40 was receiving Zantac and Omeprazole. In addition the CAA did not indicate when a hemoglobin level was last checked and how often it was supposed to be checked. Review of Physician Progress Notes dated 9/19/14, through 3/16/15, lacked evidence of documentation for indication of both medications	F 428	The surveyor's documented findings are duplicative of the findings at F 329. It is the position of the facility that there were no deficient practices related to the facility at this citation. It is the facility's intent to submit an Informal Dispute Resolution request. Refer to the facility response at F 329.	

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F 428	Continued From page 25	F 428		

and the physician only had indicated R40 was receiving only Zantac for gastroesophageal reflux disease (GERD).

R40's diagnoses included gastritis without hemorrhage, esophageal reflux, diverticulitis of colon (without hemorrhage), and anemia obtained from Physician Order Report dated and signed by physician 3/16/15. In addition the physician Order Report revealed R40 was had an order dated 3/25/13, for Prilosec (Omeprazole) enteric coated tablet 20 milligram (mg) oral once a day "Take on empty stomach" for esophageal reflux, Zantac 75 mg oral twice a day for esophageal reflux dated 3/17/13, and Ferrous Gluconate 325 mg twice a day for anemia, iron deficiency dated 5/13/13.

On 4/2/15, at 9:40 a.m. RN-A who was also the unit nurse manager verified there was no recent hemoglobin in R40's chart stated she was going to look in R40's other old chart. When asked if R40 had complaints of stomach being upset RN-A stated "No but she has diverticulosis and sometimes she has diarrhea and is better." RN-A further stated recently R40 had reported heart burn but thought it was related to the stress and had no further complaints after that and no complaints other than that in the past
-At 9:45 a.m. RN-A provided a copy of laboratory result which revealed hemoglobin had last been checked 2/12/13, with result of 9.9 (low) grams per deciliter (g/dL) reference ranges (11.8-15.5)
- At 11:21 a.m. via telephone spoken with licensed practical nurse who worked with R40's primary physician stated the doctor had her call surveyor and try to answer the questions and if was not able would call back with answers. Surveyor asked what was the indication for using both Prilosec and Zantac at the same time and

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F 428	Continued From page 26 what primary physician's recommendation was for checking hemoglobin levels for R40 as last level had been done 2/13/13, yet R40 was receiving the iron supplement twice daily for anemia. Primary physician's nurse indicated she would find out the answers and would call back. - At 12:10 p.m. the consultant pharmacist was interviewed via telephone when asked what her recommendation was for checking hemoglobin levels for R40 who had a hemoglobin last checked 2/12/13, CP stated "There should be another one in the chart. I know it has been monitored. There is no standard but I would say should be done annually." When asked what her recommendation was for using both Zantac and Prilosec CP stated R40 had a past GI bleed history when asked where the information would be in R40's chart she stated the information was at the facility with all the documentation she had reviewed. - At 12:23 p.m. the DON indicated after looking through orders that R40 had started taking Zantac on 3/17/13, and 3/25/13, for Prilosec. DON also stated after reading through several progress notes in 2013 R40 had reported stomach being upset. When asked what the indication for use was for both medications DON pointed to the physician progress notes and stated "GERD." When asked what the facility expectation was for monitoring hemoglobin level DON stated it was up to the primary physician. DON also verified after going through the three ringer binder which had the consultant pharmacist documentation there was no more documentation regarding indication for both medications as indicated by the CP on the telephone conversation. - At 2:30 p.m. no call back still from primary physician regarding indication for medications	F 428		

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F 428	Continued From page 27 use and hemoglobin level monitoring. R40 lacked an indication for receiving both Zantac (Ranitidine) and omeprazole (both used to treat esophageal reflux). In addition, the facility failed to monitor hemoglobin level for R40 who received Ferrous Gluconate (an Iron supplement). The pharmacist did not report the irregularity to the facility.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		5/12/15

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(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 431	Continued From page 28 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 4 residents (R2, R71, R85) on Elm household whose medications were observed for medication storage. In addition, the facility did not ensure multiple use vials were dated when opened on Lake and Island households. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R2, R71 and R85, which included eye drops and nasal spray, lacked dates to indicate when they were opened or the medications were expired. During the medication storage tour on 3/30/15, at 1:39 p.m. with trained medication assistant (TMA)-A, in the Elm household unit medication cart, multiple opened, used, undated and expired medication bottles were observed to be stored. During the tour the following concerns were identified: - R2's artificial tears (Dry eyes) eye drop bottle was opened, used and was undated. - R71's Timolol solution 0.5% (eye drops for glaucoma) bottle was opened, being used and	F 431	It is the intention of Auburn Home in Waconia to be compliant with the requirements at F 431 During one day of the survey, the surveyor discovered opened eye drops, a nasal spray, and a Tubercullin solution vial lacking dates as to when these items had been opened. The nurse took immediate action to remedy this finding by discarding the unlabeled medications and biological, since she was unable to ascertain when the medications & biological had been initially opened. Replacements were ordered from the pharmacy. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility licensed staff will review and discuss best practice strategies for medication and biologicals storage requirements and protocols, consistent with regulations and standards of nursing practice. Facility staff will be instructed to report irregularities in medication and biological storage practices to their supervisor and/or follow the facility's policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/02/2015

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 431	Continued From page 29 was undated. Cosopt eye drop bottle (used to treat glaucoma) was opened, being used and was undated. Xalatan eye drop bottle (used to treat glaucoma) was opened, being used and was undated. In addition, Fluticosone nasal spray (used to treat non-allergic and allergic rhinitis) bottle was opened and undated. - R85's lubricating eye drop bottle was opened and undated and R85's sodium chloride eye drop bottle was opened and was undated On 3/30/15, at 1:54 p.m. TMA-A verified medications needed to be stored properly, date when opened and discard when expired. At 1:57 p.m. TMA-A stated, the eye drop should have been labeled and would inform the nurse to take corrective actions for storing medications properly. - At 3:49 p.m. registered nurse (RN)-A verified the medications needed to be stored properly, with correct open date. The expired medications needed to be discarded from the medication cart. Further, RN-A stated the nursing staff needed to check expired medications and remove them from the medication carts. RN-A removed the concerned medications from medication cart and stated she will reorder them because she do not know when they were open. - At 4:03 p.m. the director of nursing (DON) indicated staff was supposed to date medication bottles when opened, check for expired medications, remove expired medications and re-order them from the pharmacy. On 4/1/15, at 12:58 p.m. the consultant pharmacist (CP) stated her expectation was for facility staff should discard expired medications and follow manufacturer recommendation regarding dating eye drops when open.	F 431	and procedure addressing this issue. 2. Ongoing: Weekly medication audits will be conducted to ensure that medications and biological are correctly labeled and properly stored. Variations to the facility's medication labeling and storage standards will be immediately corrected and reported on a quarterly basis to the quality assurance committee. Information obtained from this process will be integrated into quality assurance initiatives and will be reviewed, with recommendations for intervention made, during the quality assurance meetings.	

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F 431	Continued From page 30 Policy for dating medications dated 8/11, directed, "All insulin, eye, ear and nasal medications will be dated upon opening. If medications are found that have been opened and do not have an opening date, then they will be dated as of the order date listed on the medication." Saint Therese Pharmacy Medications with Accelerated Expiration Dates policy dated 9/2014, directed, "Xalatan discard after 42 days." During medication storage observation on 3/30/15, at 2:30 p.m., an open vial of Tuberculin (a solution used to test for tuberculosis) was observed in the medication cart on the Lake unit. On the vial in hand-written letters was the word "stock". Registered nurse (RN)-C verified it lacked a date when opened and on the package it was stored in. RN-C stated staff was expected to date the vials when opened. RN-C further explained the the Tuberculin solution was used for new residents admitted to the facility in need of a tuberculosis skin test (TST). On 3/30/15, at 12:06 p.m. the DON stated she absolutely expected staff to date Tuberculin solution vials when opened. On 3/30/15, at 3:48 p.m. an open vial of tuberculin was observed undated on the Island household medication cart. TMA-C verified the vial was opened, undated, and approximately half full. TMA-C stated, "I don't give the injections to the residents, just nurses do." On 4/2/15, at 12:29 p.m. the DON stated the multiple use vials were supposed to be dated by staff when opened.	F 431		

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	245583	A. BUILDING **02 - NEW BLDG** B. WING _____	**04/01/2015**

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AUBURN HOME IN WACONIA	**594 CHERRY DRIVE** **WACONIA, MN 55387**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 01, 2015. At the time of this survey, Auburn Home in Waconia was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 04/30/2015

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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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Auburn Home in Waconia was constructed in 2007, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 32 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		5/12/15

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K 147	Continued From page 2 Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect the any resident, staff and visitors in this area of the facility. Findings include: Observations during the facility tour on April 01,2015, between 10:00am and 12:45 pm, revealed that extension cords are in use in the following areas: 1) Microwave in the employee break room 2) Refrigerator in the administrator office The Director of Maintenance (DS) verified this deficiency at the time of the inspection and during the exit conference along with the administrator (WW)	K 147	It is the intention of Auburn Home in Waconia to be in full compliance with all NFPA Life Safety Code Standards. The cited findings were corrected immediately during the facility tour. The surge protector strips were removed and the microwave in the employee break room and the refrigerator in the administrator's office were plugged directly into the wall outlet. In order to maintain compliance, the safety committee will conduct quarterly audits to ensure that appliances are not plugged into extension cords or surge protector strips. Findings will be reported to the QA Committee and reviewed at the committee's quarterly meeting for analysis and recommendation.	