Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: CCN:245604
Cycle Start Date: April 30, 2026

Dear Administrator:

On April 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 30, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING B. WING	**04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
E0000	Initial Comments On 4/27/26 through 4/30/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/19/2026
F0000	INITIAL COMMENTS On 4/27/26 through 4/30/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (iQIES #). NO deficiencies were cited. H56041619C/2666460 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/19/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0576 SS = F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered to	F0576	All nursing and administrative staff (RN, LPN, CNA, Nurse Manager, Scheduler and Administrative Secretary) have been retrained on the Mail Delivery policy. To ensure all residents receive their mail timely going forward, Monday-Friday it will be the procedure for the Administrative Secretary to deliver any mail received. On Saturdays, it is the responsibility of the evening Charge Nurse to go to the front desk to obtain any mail received and deliver it to residents. A sign off form has been created for the Charge Nurse to document mail was delivered on Saturdays. Ongoing compliance will be monitored by the DON via random audit of the Charge Nurse mail delivery documentation form2x/month for 3 months. This data will be presented to QAPI for review and any adjustments that may be needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0576 SS = F	Continued from page 2 residents on Saturdays for 4 of 4 residents (R33, R34, R14, R24) who voiced concerns with mail delivery during Resident Council. This had the potential to affect all residents residing in the facility. On 4/30/26 at 9:33 a.m., a Resident Council meeting was held with four residents from varied areas of the facility. R24 stated mail was not delivered to residents on Saturdays. This was confirmed by R33, R34 and R14. R24 indicated mail delivered by the post office on Saturdays would be left on the receptionist's desk near the front entrance. On Monday morning the receptionist would sort and deliver the mail to residents. During interview on 4/30/26 at 1:09 p.m., Secretary (S)-A stated it was her job Monday through Friday to sort and deliver the mail. SA stated on the weekend it would be the responsibility of the nursing supervisor. During interview on 4/30/26 at 1:22 p/m., registered nurse (RN)-A stated she was unaware collecting and passing mail was part of her responsibilities on the weekends. RN-A then stated she did not have time to deliver mail when she was the only nurse in the building overseeing all staff and residents. RN-A stated she did not have any back up assistance available to her on the weekends. During interview on 4/30/26. At 1:29 p.m., Administrator stated it was the responsibility of the secretary at the front desk to deliver mail. Administrator went on to say occasionally nursing staff would deliver mail on the weekends but not on a regular basis, and mail delivered over the weekend was typically delivered Monday after the front desk staff arrived. Administrator stated it was her expectation mail would be delivered to the residents the same day it was delivered to the facility. An undated policy with no review dated titled Policy of Mail Delivery indicated residents of [facility] have the right to receive and send mail both personal and business in nature and all letters, documents and packages will be delivered 6 (six) days a week, Monday thru Saturday. It is the duty and responsibility of [facility] to see that mail delivered to [facility] is distributed to each resident in a timely fashion.	F0576		06/19/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	We would like it noted that the facility also provided a policy regarding food brought in by residents.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0812 SS = F	Continued from page 3 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to store and label food properly, dispose of undated and expired food items to reduce the risk of foodborne illness. This had the potential to affect all the residents who were provided meals from the kitchen. Findings include: During initial tour and interview of kitchen on 4/27/26 at 1:03 p.m., with Dietary Director (DD) the following was observed inside the walk-in cooler: an opened box of undated chicken stock an opened box of undated turkey stock an approximately 4x4x8 inch metal dish containing sliced carrots lacked an open or use by date, an approximately 4x4x8 inch metal dish with contents identified by DD as pizza sauce lacked an open or used by date. DD stated he was unsure of what the food storage policy stated in regard to leftover food, but he believed all food was to be dated with both an	F0812	Continued from page 3 The Food Storage policy was reviewed and revised to ensure clear instructions on proper labeling of opened food. This policy includes both food stored in the kitchen as well as the refrigerator in the kitchenette which is for resident use. All dietary staff were retrained on proper labeling of open and food as well as expiration times for proper disposal. It is the responsibility of the kitchen staff to monitor and dispose of improperly labeled food or food that is expired daily in both the kitchen and kitchenette. Residents were provided instruction on food storage procedures for food they or visitors bring for them to store in the kitchenette refrigerator/freezer. Ongoing compliance will be monitored by the facility Dietary Director by completing a random audit of both the kitchen and kitchenette 2x/week for 4 weeks and then 2x/month for 2 months. This data will be brought to QAPI for review and any input on adjustments needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0812 SS = F	Continued from page 4 opened on and use by date. During observation of refrigerator in kitchenette by north nursing station on 4/28/26 at 2:48 p.m., the following was observed in the freezer: a loaf of multigrain bread was not sealed, dated and was covered in thick white frost, a gallon bucket of Kemps vanilla ice cream with a jack o lantern pattern on the outside approximately 1/3 full was covered with a thick layer of white frost on both the inside and outside of the bucket, a gallon bucket of Shoppers Value vanilla ice cream approximately 1/3 full with thick white frost covering the ice cream lacked an open date or use by date. Director of Nursing confirmed the above items lacked proper labeling and should have been discarded. During interview on 4/29/26 at 2:54 p.m., Administrator stated the facilities left over food policy should be followed by all dietary staff. Stated she was unaware of leftovers stored in the kitchen or anywhere else in the facility. Administrator stated dietary staff 'batch cooked' to avoid excess food being made and therefore eliminating the need to store leftovers. A policy titled [facility] Food-No Leftover Food Retention Policy indicated no left-over food was permitted to be saved, stored, cooked, or reused. Any food remaining after service must be discarded immediately.	F0812		06/19/2026
F0572 SS = E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F0572	The Director of Life Coach Services has posted the most current Resident Rights and has provided a copy of this to all residents, including R33, R34, R14 and R24. In addition, R33, R34, R14 and R24 along with all residents have been informed of where they can locate this within the facility. An updated copy is also in the admission packets going forward. The Director of Life Coach Services has also developed a calendar of resident rights to be reviewed monthly at each resident council meeting. The Director of Life Coach Services will present this information, provided the residents agree to her being present. Should residents decline to have her present for their resident council meetings, information regarding that month's resident right will be provided in writing to residents. Resident council notes are to include which resident right	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0572 SS = E	Continued from page 5 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide ongoing communication to residents about their rights (e.g., through resident groups) for 4 of 4 residents (R33, R34, R14, R24) who attended the council meetings. Findings include: R33 quarterly minimum data set (MDS) dated 3/27/26, indicated R33 was cognitively intact R34 quarterly MDS dated 2/27/26, indicated R34 was cognitively intact R14 quarterly MDS dated 4/14/26, indicated R14 was cognitively intact R24 quarterly MDS dated 2/27/26, indicated R24 was cognitively intact Resident council meeting minutes dated November 2025 through April 2026, lacked evidence resident rights had been reviewed or included in meeting discussions. During a resident council meeting on 4/30/26 from 9:33 a.m. to 10:48 a.m., R33, R34, R14 and R24 stated they regularly attended resident council meetings and did not recall a time when resident rights had been discussed. All four residents stated they did not know where resident rights were posted in the facility. Resident Right poster hung in a hallway across from the beauty salon. During an interview on 4/30/26 at 1:04 p.m., life enrichment director (LED) stated she was responsible for taking minutes at resident council meetings. LED stated a typical meeting consisted of review of previous months' topics, new residents' concerns and if there were no concerns brought forward, she would go through each department and ask if they had concerns specific to each department. LED stated a representative of the state Ombudsman office had attended resident council	F0572	Continued from page 5 education was provided on. Ongoing compliance will be monitored by the Administrator by auditing resident council notes monthly x3 months to ensure documentation of resident rights discussed. Admission packets will also be randomly audited 2x/month for 3 months by the Administrator to ensure Resident Rights are included. This data will be brought to QAPI for review and to provide any input on adjustments that may be needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0572 SS = E	Continued from page 6 and she believed they had discussed resident rights. LED was unable to locate any documentation in resident council notes to support resident rights were discussed. LED stated it was important for residents to understand their rights and the residents of the facility were vulnerable to having others make all decisions for them, their rights violated and were more susceptible to abuse. During an interview on 4/30/26, at 1:49 p.m., Administrator (Admin) stated resident rights were reviewed upon admission. Admin stated if social workers were in attendance for resident council, they would be responsible for reviewing resident rights. Admin stated it was something the facility was working on to standardize recently. Admin stated it was important for residents to know and understand their rights to empower them to self-advocate and went on to state many residents' rights were directly related to how the residents wanted their lives to look.	F0572		06/19/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or	F0550	It is the policy and intention of Auburn Manor 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 int eh 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 of the requirements. 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. It is the intention of Auburn Manor to be complaint with the requirements. In the spirit of cooperation and resolution of this incident and preventing any going forward, the following Plan of Correction has been developed: Nurses and TMAs have been re-educated on call light times and expectations of 90% of call lights being answered within 25 minutes or better. R33 and R34 along with all other current residents have been re-educated on the grievance policy and encouraged to file a grievance if they have care concerns.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0550 SS = D	Continued from page 7 resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 (R33, R34) residents reviewed for dignity, received services in a dignified manner to promote quality of life when staff failed to respond timely to call light and provide toileting assistance resulting in episodes of incontinence. Findings include: R33's admission minimum data set (MDS) dated 11/11/22, indicated R33 was cognitively intact and had the following diagnoses: history of urinary tract infections (UTI's), depression, generalized weakness and lymphedema (swelling caused by an accumulation of fluid in the tissues). During interview on 4/27/26 at 3:13 p.m., R33 stated she frequently waited for assistance to use the bathroom and at times it could be over an hour. R33 stated it had caused her to become incontinent of both bowel and bladder. She went on to state "it doesn't make me feel good. Its degrading. No one wants to sit in their pee or poop". Review of R33's call light logs from 3/29/26 through 4/28/26 indicate R33 had call lights greater than 30 minutes on 26 occasions. R34's admission MDS dated 5/8/23, indicated R34 was cognitively intact and had the following diagnoses: non-traumatic spinal cord disfunction, peripheral vascular disease (a condition leading to low blood flow to limbs), and personal history of UTI's. During interview on 4/29/26 at 11:51 a.m., R34 stated she needed to use a mechanical lift (a machine to assist in transferring a person from a bed or chair to another location) which required two	F0550	Continued from page 7 DON and Administrator receive daily call light reports. Call light reports will be audited by the DON 2x/wk for 4 weeks then 2x/month for 2 months to monitor for ongoing compliance. This information will be presented to QAPI for review and any adjustments that may be needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0550 SS = D	Continued from page 8 staff to operate. R34 stated staff frequently had to wait for additional staff assistance and had become incontinent on more than one occasion while waiting. She went on to state she was embarrassed by this and felt like she was being forgotten because she was old. Review of R34's call light logs from 3/29/26 through 4/26/26, indicated R34 had call lights greater than 30 minutes on 14 occasions. During interview on 4/30/26 at 1:22 p.m., Director of Nursing (DON) stated she expected staff to answer call lights as quickly as possible and ideally under 15 minutes. DON confirmed call light logs revealed call lights extending beyond 30, 45 and 60 minutes. DON could not offer an explanation as to why call lights were not being answered faster. DON stated if a resident had to wait an extended amount of time and became incontinent it could have a negative impact on the residents. DON went on to state residents lived at the facility to receive assistance and care. Waiting for a long period of time could result in a resident not receiving the care they needed and could harm them emotionally, holistically and physically. DON stated it was never acceptable if a resident felt embarrassed or humiliated after becoming incontinent because of waiting an extended period for a call light to be answered. A call light policy was requested but not received.	F0550		06/19/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F0585	The grievance policy has been reviewed and it was determined that no edits are needed. All residents have been provided a copy of the grievance policy and educated on where to find forms and how to file a formal grievance both in person and anonymously by the Director of Life Coach Services. Facility Leadership (DON, Nurse Manager, Life Coach, Director of Life Coach Services and Director of Life Enrichment) was re-educated on the grievance policy, where to find forms to assist a resident in completing a formal grievance, and how a resident may submit a grievance anonymously. Ongoing, the grievance policy will be reviewed and documented as reviewed during resident care conferences and resident council meetings. Information regarding the ombudsman and where to	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0585 SS = D	Continued from page 9 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the	F0585	Continued from page 9 locate their information will also be discussed and documented during resident council meetings. Ongoing compliance will be monitored by the Director of Life Coach Services by randomly auditing 2 residents/month for 3 months to ensure they know how to file a grievance. This data will be brought to QAPI for review and input on any adjustments needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0585 SS = D	Continued from page 10 steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were aware how to file grievances anonymously, for 4 of 4 residents (R33, R34, R24, and R14) reviewed for grievances. Further, the facility failed to maintain a grievance log for a minimum of 3 years. This had the potential to affect all residents residing in the facility. Findings include: During the initial entrance conference on 4/27/26 at 12:11 p.m., Director of Nursing (DON) stated there were no grievances for the previous six months. On 4/30/26 at 9:30 a.m., R33, R34, R24, and R14 stated they were unclear how to file an official grievance, or where to find a grievance form to assure anonymity. All four residents stated they could talk to the Director of Nursing (DON). DON had instructed residents all grievances or concerns were to be handled internally. During interview on 04/30/2026 at 1:22 p.m., DON stated a grievance is any report of a concern a resident feels necessary to discuss about their care or about the facility. DON stated if a resident had a concern they were to bring it to her, the social worker (SW) or any staff and then depending on the concern would determine how it was handled. DON stated a resident could fill out the form or staff could assist them if a resident brought forward a verbal grievance. DON stated residents were	F0585		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0585 SS = D	Continued from page 11 encouraged to bring grievances and concerns forward in real time instead of waiting until resident council. She went on to state she verbally followed up with a one-to-one meeting in the resident's room. DON stated the facility did have a process for tracking grievances which included a paper grievance form and a grievance log to be filled out for every reported grievance. DON stated although residents had verbally brought forward concerns, she did not have any copies of grievances, grievance investigations/resolutions, nor did she have a grievance log tracking resident grievance A facility policy titled Grievance, Complaint & Non-Retaliation with a last review date of 1/25/22 indicated the following: Residents are encouraged and supported in bringing their concerns and complaints forward to any [facility] and Services employee. If an informal resolution cannot be found, the resident will be offered the opportunity to file a formal grievance report form. The resident may file a grievance orally to an employee. The employee is to complete the grievance report form with the resident's oral report. The grievance will be forwarded to the grievance official for review within a reasonable expected timeframe. The grievance official will maintain a record of any formal complaints filed. Records will be kept for at least 3 years and will include the dated original complaint, the investigation, and resolution of the compliant. Records will be available for review by the commissioner of health or a designated representative.	F0585		06/19/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F0755	Notes on R14 were reviewed and no concerns were noted due to medications not administered as ordered on 4/30/2026. All nurses (LPNs and RNs) and TMAs have been re-educated on the person centered med pass policy as well as Omnicare guidelines of medications being administered within 1 hour of the scheduled time to prevent ongoing concerns in medication administration time for R14 and all other facility residents. Ongoing compliance will be monitored by random audit of medication passes by the DON or consulting pharmacist monthly for 3 months. This data will be brought to QAPI for review and any adjustments that may be needed.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0755 SS = D	Continued from page 12 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure mediations were administered in accordance with physician orders for 1 of 1 residents (R 14) reviewed for medications administration. Findings include: R14's quarterly minimum data set (MDS) dated 4/14/26 indicated R14 was cognitively intact and had the following diagnoses: Multiple Sclerosis, Hypertension, Neurogenic bladder, Chronic Obstructive Pulmonary Disease and Hyperlipidemia. During interview on 4/30/26 at 10:48 a.m., R14 stated she had not received her scheduled 7:00 a.m. medications. R14's medication administration record on 4/30/26 at 10:52 a.m., revealed blank boxes for R14's scheduled 7:00 a.m. medications indicating they had not been administered. R14 was scheduled but did not receive the following medications: Glucosamine-Chondroitin 500-400mg tablet- 1 tab Lisinopril 20mg -1 tab Omeprazole 20mg -1 capsule Multivitamin tablet -1 tab Trimethoprim 100mg -1 tab	F0755		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0755 SS = D	Continued from page 13 Fluticasone-Salmeterol Inhalation Aerosol 250-50 MCG/ACT – 1 puff Nystatin external powder 100000 u/gm Oxybutynin Chloride 5mg -1 tab Baclofen 10mg -1 tab Gabapentin 300mg – 3 capsules During an interview on 04/30/2026 1:22 p.m., Director of Nursing (DON) stated medications were expected to be delivered within one hour before or after their scheduled time. DON reviewed R14's medication administration record and confirmed R14 had not received her scheduled medications within the allowable time frame. DON stated it was important for residents to receive medications as scheduled and physician order because the medications are prescribed by a physician to treat specific diagnoses and should be given as the prescriber orders for residents to achieve the best outcomes. Facility policy title Person-centered Medication Pass indicated Auburn Manor will implement a person-centered medication pass while following manufacturer guidelines as well as applicable State and Federal law and regulations. The policy indicated medications will be scheduled for administration time windows unless clinical contradictions exist or prescribing directions. The policy lacked specific guidelines for medication administration times.	F0755		06/19/2026
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;	F0887	The Infection Preventionist was re-trained on the vaccination policy. R6 was offered and educated on the current COVID 19 vaccination. An audit was completed on all current residents to ensure they received education and offered the COVID 1 9 vaccination - no other were affected. Ongoing compliance will be monitored by randomly auditing 2 new residents /month for 3 months to ensure they were offered and educated on COVID 19 vaccination. This data will be brought to QAPI for review and any adjustments necessary.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0887 SS = D	Continued from page 14 (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to ensure COVID-19 vaccinations were offered to 1 of 5 residents (R6) reviewed for COVID-19 vaccination status.	F0887		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
F0887 SS = D	Continued from page 15 Findings include: R6's quarterly minimum data set (MDS) dated 4/4/26, indicated R6 was admitted to the facility on 12/10/25, and had the following diagnoses: high blood pressure, hyperlipidemia (high levels of fat in the blood), and malnutrition. R6's undated client information vaccination record indicated R6 was overdue for their COVID-19 vaccination. R6's medical record lacked any evidence a COVID-19 vaccination was offered or provided. On 4/30/26 at 10:00 a.m., the Infection preventionist (IP) stated they had just started in this role recently. R6 had been on a list of the previous infection preventionist to be completed, however, was unable to find any supportive documentation it was ever offered or completed. The IP stated they would have expected the vaccination to have been completed within a few days of R6's admission and confirmed it should have already been completed but had not been. On 4/30/26 at 11:01 a.m., the director of nursing (DON) confirmed R6 had not been offered or received the COVID-19 vaccination. Their expectation was it would have been completed within a week of admission. The DON stated importance of supporting the residents with their treatments, preventing any infections, and supporting them in their care choices. The facility COVID Immunization policy dated 4/17/23, indicated [facility] will offer the COVID-19 immunizations and/or boosters to all residents.	F0887		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/28/2026. At the time of this survey, Auburn Manor Chaska was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		05/19/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Auburn Manor is a one-story building with no basement. The original building was constructed in 1988, with one building addition constructed in 1992. Both buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. A 2006 building addition, which is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. Both buildings were surveyed as one. 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 nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 60 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/19/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance	K0921	Forms for documenting inspection on all PCREE were obtained from the Fire Marshall. Proper test equipment has been ordered and received. Inspection and testing has been completed on all PCREE and documentation is kept by the facilities manager in a binder and available for review.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	**501 OAK STREET , CHASKA, Minnesota, 55318**

(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
K0921 SS = F Bldg. 01	Continued from page 2 with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/28/2026 at 09:00 AM, it was revealed that the facility provided electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical, medical equipment, were present at the facility, and at the time of the survey, the facility could not provide documentation showing that these devices had been inspected. An interview with the Facilities Services Manager and Director of Facility Services verified this deficient finding at the time of discovery.	K0921	Continued from page 2 Ongoing compliance will be monitored by the Facilities Director by auditing the binder for proper documentation 1x/month for 3 months. This data will be present to QAPI for review and any adjustments that may be needed.	06/19/2026