DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 13, 2026

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

RE: CCN:245583

Cycle Start Date: June 18, 2026

Dear Administrator:

On June 18, 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 September 18, 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 December 18, 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - NEW BLDG** B. WING	(X3) DATE SURVEY COMPLETED **06/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	**594 CHERRY DRIVE , WACONIA, Minnesota, 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
K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 15, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Auburn Home in Waconia, 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		07/21/2026

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

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K0000 Bldg. 02	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. Building Info: 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 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/21/2026
K0345 SS = F Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by:	K0345	The required semi-annual fire alarm system inspection was verified as completed in April 2026 in accordance with requirements. Documentation of the inspection has been obtained and is maintained in a designated location to ensure it is readily available for review. Environmental Services staff responsible for coordinating and maintaining required Life Safety Code inspection records will receive education regarding the timely completion of required fire alarm system inspections and the requirement to maintain inspection documentation in a readily accessible location. Education will be completed by July 31, 2026. The Environmental Services Director or designee will	07/31/2026

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K0345 SS = F Bldg. 02	Continued from page 2 Based on a review of available documentation and staff interview, the facility failed to maintain the Fire Alarm System per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3, 14.4, 14.5.1, 14.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/15/2026 at 11:30 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system semi-annual inspection is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 verify that documentation of the required semi-annual fire alarm system inspection is maintained and readily available, and that the next required semi-annual inspection is scheduled and completed within the required timeframe. Audit results will be reviewed through the facility's QAPI process. Additional education and corrective action will be implemented as indicated to ensure ongoing compliance.	07/31/2026

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E0000	Initial Comments On 6/15/26 through 6/18/26, 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		
F0000	INITIAL COMMENTS On 6/15/26 through 6/18/26, a standard recertification survey (S5583037-0) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605		

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.

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F0605 SS = D	Continued from page 1 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0605		

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F0605 SS = D	Continued from page 2 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that	F0605		

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F0605 SS = D	Continued from page 3 medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure physician-ordered monitoring for potential adverse effects related to antipsychotic medication use was completed when orthostatic blood pressures (BP) were not obtained as ordered for 1 of 3 residents (R7) reviewed for unnecessary psychotropic medication use. Findings included: R7's quarterly Minimum Data Set (MDS), dated 5/11/26, identified R7 had moderately impaired cognition, and diagnoses included chronic diastolic heart failure (a condition where the heart does not fill properly, which may affect blood flow), hypertension (high blood pressure), anxiety disorder, and depression. The MDS further identified R7 received antipsychotic, antianxiety, antidepressant, and diuretic medications. R7's physician orders, print date of 6/18/26 , identified an order for Olanzapine 5 milligrams (mg) by mouth two times daily for psychosis related to depression, with target behaviors including anxiety, apathy, and somatic symptoms (physical symptoms related to emotional distress) such as dizziness and nausea, initiated 4/3/25. R7's physician orders further identified an order to obtain monthly orthostatic blood pressures (lying, sitting, standing blood pressures) due to antianxiety, antidepressant, and antipsychotic medication use, initiated 1/28/25. R7's electronic health record (EHR) from January 2026 through May 2026 lacked evidence orthostatic blood pressures were obtained as ordered. The EHR failed to identify staff completed monitoring to assess R7 for potential medication-related adverse effects, including blood pressure changes associated with antipsychotic medication use. During an interview on 6/18/26 at 7:53 a.m., licensed practical nurse (LPN)-A stated nurses completed orthostatic blood pressures when the task appeared on the treatment administration record (TAR) indicating the monitoring was due. During an interview on 6/18/26 at 9:02 a.m., registered nurse case manager (RN)-A stated orthostatic blood pressures were completed for residents who received antipsychotic medications or had concerns related to orthostatic blood pressures. RN-A reviewed R7's EHR and verified the	F0605		

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F0605 SS = D	Continued from page 4 orthostatic blood pressure order was active, and the order type had not generated a task for nursing staff to document completion. RN-A confirmed orthostatic blood pressures had not been completed since the order was initiated on 1/28/25. RN-A stated monitoring orthostatic blood pressures was important to identify potential adverse effects from medications and blood pressure changes, which could increase a resident's risk for falls. During an interview on 6/18/26 at 9:16 a.m., director of nursing (DON) stated orthostatic blood pressure monitoring was important due to the potential for increased fall risk and adverse effects, including increased confusion and dizziness. DON stated physician-ordered monitoring should have been completed to assess residents for potential medication-related concerns. The facility's Psychotropic Medication Use policy, revised 3/1/25, identified guidelines for the safe and appropriate use of psychotropic medications to ensure effective treatment of mental health conditions while minimizing risks and adverse effects. The policy identified medications used to treat behaviors required a clinical indication and should be used at the lowest possible dose to achieve the desired therapeutic effect. The policy further identified medications used to treat behaviors should be monitored for effectiveness, risks, benefits, and potential adverse consequences.	F0605		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing	F0880		

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F0880 SS = D	Continued from page 5 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP	F0880		

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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
F0880 SS = D	Continued from page 6 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff implemented infection prevention and control practices when staff failed to wear required personal protective equipment (PPE), including gowns and gloves, during high-contact resident care activities for 1 of 1 resident (R4) reviewed for enhanced barrier precautions (EBP). Findings include: R4's significant change Minimum Data Set (MDS), dated 5/26/26, identified R4 had intact cognition, and diagnoses included benign prostatic hyperplasia (BPH; enlarged prostate which may affect the ability to empty the bladder), chronic obstructive pulmonary disease (COPD; chronic lung disease that affects breathing), severe protein-calorie malnutrition (lack of adequate nutrition which may affect the body's ability to heal and fight infections), and weakness (decreased strength which may affect mobility and ability to complete daily activities). The MDS further identified R4 required an indwelling urinary catheter (a tube inserted into the bladder to drain urine). R4's care plan, dated 6/18/26 identified R4 required an indwelling urinary catheter and EBP. During observation on 6/16/26 at 12:40 p.m., trained medication aide (TMA)-A and nursing assistant (NA)-A assisted R4 with a transfer from the wheelchair to bed utilizing a mechanical lift. TMA-A and NA-A provided hands-on, physical assistance during the transfer. However, TMA-A and NA-A had not worn gown or gloves while the transfer care was provided. During interview on 6/16/26 at 12:47 p.m., TMA-A stated R4 was on EBP due to an indwelling catheter, and staff were required to wear gowns and gloves when catheter cares were completed. TMA-A stated PPE was not worn during R4's transfer because staff had not provided catheter care. During observation on 6/16/26 at 4:39 p.m., NA-A and NA-B assisted R4 with a transfer utilizing a mechanical lift. NA-A and NA-B provided hands-on assistance during the transfer. NA-A rolled R4 side to side in bed to place the lift sling underneath R4, adjusted the bed, lowered the lift arm, and attached the sling to the lift. NA-A then applied gloves, picked up R4's catheter bag from the bed frame,	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE , WACONIA, Minnesota, 55387

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F0880 SS = D	Continued from page 7 and attached the catheter bag to the sling. After R4 was transferred into the wheelchair, staff removed the lift sling from underneath R4. However, NA-A and NA-B failed to wear a gown during the transfer, and only NA-A wore gloves while handling R4's catheter bag. During interview on 6/16/26 at 4:47 p.m., NA-A stated R4 was on precautions "just for catheter" and staff only needed to wear gown and gloves when providing catheter cares, such as emptying the catheter bag. During interview on 6/17/26 at 1:12 p.m., NA-B stated R4 was on precautions related to the catheter and staff were expected to wear gowns and gloves anytime they had contact with R4. During interview on 6/18/26 at 9:05 a.m., registered nurse case manager (RN)-A stated R4 was on EBP and staff were expected to wear a gown and gloves when any hands-on cares were provided. RN-A stated PPE use was important to prevent the spread of infection. During interview on 6/18/26 at 9:17 a.mm., the infection preventionist (IP) stated staff were expected to follow infection prevention practices, including appropriately donning and doffing PPE. The IP stated residents on EBP required staff to wear gowns and gloves during high-contact resident care activities. The IP confirmed transfers required PPE because staff had close physical contact with the resident. During interview on 6/18/26 at 9:20 a.m., the director of nursing (DON) stated staff were expected to wear gowns and gloves whenever they had close contact with residents on EBP. The DON stated personal cares and transfers required gowns and gloves to reduce the risk of spreading infection. The facility's Enhanced Barrier Precautions policy, reviewed 7/9/26, identified the facility would reduce the transmission of Centers for Disease Control and Prevention (CDC)-targeted and epidemiologically important multidrug-resistant organisms (MDROs) through the use of EBP. The policy identified EBP expanded the use of PPE, and required staff to wear gowns and gloves during high-contact resident care activities to reduce the risk of transferring MDROs to staff hands and clothing. The policy identified residents with wounds and/or indwelling medical devices, including urinary catheters, required EBP even if the resident was not known to have an infection or MDRO. The policy further identified	F0880		

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F0880 SS = D	Continued from page 8 gowns and gloves were required during high-contact resident care activities, including transferring, providing hygiene, toileting, and urinary catheter device care.	F0880		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with	F0628		

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F0628 SS = A	Continued from page 9 paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F0628		

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F0628 SS = A	Continued from page 10 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = A	Continued from page 11 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 1 resident (R41) reviewed for transfer and/or discharge. Findings include: R41's admission Minimum Data Set (MDS), dated 3/20/26, indicated R41 was cognitively intact, and diagnoses included osteoporosis with current right	F0628		

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F0628 SS = A	Continued from page 12 humerus fracture, pulmonary fibrosis, chronic pain, and congestive heart failure. R41's medical record identified the following census information: Resident transferred to the hospital on 4/12/26, returned on 4/14/26 Resident discharged from facility on 4/23/26. On 6/18/26 at 9:37 a.m., facility was not able to produce documentation for ombudsman notification for April 2026. The notification list was requested on 6/16/26, however, the facility provided a statement that facility had contacted the ombudsman office requesting documentation they had received by facility, documentation was not received. During interview on 6/18/26 at 9:44 a.m., Social worker (SW)-A stated notifications of transfers and discharged were submitted to the ombudsman office for each month during the first week of the following month. SW-A stated copies of the notification sent with confirmation page from the fax were kept "forever". However, the facility was unable to locate the notifications that had been submitted in March and April 2026. When interviewed on 6/18/26 at 9:58 a.m., administrator stated because not all discharges were safe discharges, notification to the ombudsman was important to provide an opportunity for ombudsman to follow up with discharged residents to ensure safety. The facility's Individual Transfer and Discharge policy, dated 7/29/25, indicated the appropriate ombudsman would be notified of all facility initiated discharges, including hospitalizations.	F0628		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 6, 2026

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

RE: CCN: 245583
Cycle Start Date: June 18, 2026

Dear Administrator:

On August 4, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112