Electronically Delivered

September 28, 2023

Licensee
Auburn Courts
501 Oak Street North
Chaska, MN 55318

RE: Project Number(s) SL20425015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider’s resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20425015-0 On August 29, 2023, through August 31, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 40 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 800	Continued From page 1 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-C, Director of Housing (DOH)-E, and Maintenance Director (MD)-F. During the facility tour, survey staff observed the following: In the restroom by the dining room on the first floor, it was observed that the door had been disabled by removing the closure arm or closure device. The doors had a portion or remnants of the closure device still mounted on the door. The	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 800	Continued From page 2 door closure device is required to make the door close and positively latch for safety purposes. In the laundry room on the first floor, it was observed that the door was sticking badly to the floor and the door did self-closing. The door should close and latch completely to maintain the fire resistance integrity of the room. In the laundry room on the second floor, it was observed that the door did not close due to the hardware did not latch correctly. The door was a fire-rated door, and the rated door should close and latch completely to maintain the fire resistance integrity of the room. In the laundry room on the third floor, it was observed that the door did not close due to the hardware did not latch correctly. The door was a fire-rated door, and the rated door should close and latch completely to maintain the fire resistance integrity of the room. It was also observed that the door was propped open with a wood door wedge. The door wedge would prevent the doors from closing properly in the event of a fire. In the north wing corridor on the third floor, it was observed that the fire-rated compartment door with a magnetic hold open did not close or positively latch when the magenta was released from the open position. MD-F stated that the door was rubbing against the door frame and needed to be adjusted. Door magnets release the door from the open position in the event of a fire, and the door must positively latch to protect the occupants and to contain the spread of fire. During the facility tour, LALD-C, DOH-E, and MD-F visually verified these deficient findings at	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 800	Continued From page 3 the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 810	Continued From page 4 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on August 29, 2023, at approximately 1:00 p.m. with toured the facility with the Licensed Assisted Living Director (LALD)-C, Director of Housing (DOH)-E, and Maintenance Director (MD)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. On the facility tour, it was observed that the posted fire safety and evacuation plans did not have the number of resident rooms identified. This deficient condition was visually verified by LALD-C, DOH-E, and MD-F accompanying the tour and verified that the fire safety and evacuation plans for the facility lacked these	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
0 810	Continued From page 5 provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident reassessment and failed to complete an assessment not to exceed	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
01620	Continued From page 6 90 calendar days from the previous assessment for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on June 20, 2022. R5's Functional Assessment dated February 11, 2023, was completed by RN-A and contained all required content for the Uniform Assessment Tool as required per Minnesota Administrative Rule 4659.0150. R5's Focus Assessment dated July 14, 2023, was labeled as a "C. LPN Monitoring," and was completed by a licensed practical nurse (LPN). The assessment lacked multiple areas required per Minnesota Administrative Rule 4659.0150. R5's Functional Assessment was required to be completed by May 12, 2023, which was 90 calendar days from February 11, 2023. R5's Addendum A (Section IV-2) [licensee] Service Plan dated August 1, 2023, indicated R5 received assistance with showers, dressings, diabetic care, and medication management. On August 30, 2023, at 1:50 p.m., clinical nurse supervisor (CNS)-D stated R5's Functional	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
01620	Continued From page 7 Assessments should have been completed no greater than 90 calendar days after the previous assessment. CNS-D stated licensee recently had a survey at a sister location which operated similarly and recognized the requirements for the resident assessments was not being met. CNS-D stated the licensee had implemented changes at this location and all residents with assisted living services as indicated in Minnesota Statute 144G.08 Subd. 9 (6-13) would have Functional Assessments completed by a RN and within 90 calendar days of the previous assessments. The licensee's Assessment Guide/Expectations policy dated April 2022, indicated a RN would complete licensee's Functional Assessment at the start of care and at least annually. The policy incorrectly indicated licensee's Focus Assessment would be used for 14-day and 90-day visits and could be completed by an LPN for residents with assisted living services indicated in Minnesota Statute 144G.08 Subd. 9 (6-13). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
01880	Continued From page 8 Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of four residents (R3) reviewed with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on October 6, 2021, and resided in the licensee's secured unit. R3's Addendum A (Section IV-2) [licensee] Service Plan dated August 1, 2023, indicated R3 received the service of medication administration and when medications are managed by licensee, medications would be securely stored in centrally locked cabinets only accessible by delegated staff. R3's Functional Assessment dated August 24, 2023, indicated under the section, "Medication & Treatment," R3's medications were stored in a centrally locked mediations cart. On August 30, 2023, at approximately 8:00 a.m., the surveyor observed an open container of calcium carbonate (common over the counter medication used to treat acid or indigestions) and an open tube of hydrocortisone cream (common over the counter cream used to treat redness,	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20425	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN COURTS	501 OAK STREET NORTH CHASKA, MN 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) COMPLETE DATE
01880	Continued From page 9 swelling, or itching of the skin) located in R3's bathroom cabinet. On August 30, 2023, at 12:40 a.m., clinical nurse supervisor (CNS)-D stated no medications should have been stored in R3's room. CNS-D stated all medications for R3 should be stored in the secured medication cart. CNS-D stated they think a family member may have brought the medications in and the licensee was unaware R3 had the medications in their room. CNS-D removed the medications from R3's room. The licensee's Medication Management: Attainment/Storage/Disposition/Reconciliation policy dated June 2022, indicated medications would be centrally stored in a locked medication cart. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *08/29/23*
Time: 16:04:38
Report: 1018231141

Food and Beverage Establishment Inspection Report

Location:
Auburn Courts
501 Oak Street North
Chaska, MN55318
Carver County, 10

Establishment Info:
ID #: 0037863
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524489303
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding/ BUTTER
Temperature: 41 Degrees Fahrenheit - Location: 1ST FLOOR MEM CARE COOLER
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: 2ND FLOOR COOLER
Violation Issued: No

Process/Item: Cold Holding/ EGG
Temperature: 40 Degrees Fahrenheit - Location: 3RD FLOOR EAST COOLER
Violation Issued: No

Process/Item: Cold Holding/ SOUR CREAM
Temperature: 41 Degrees Fahrenheit - Location: 3RD FLOOR NORTH COOLER
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: 1ST FLOOR COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

ESTABLISHMENT GETS ALL FOOD CATERED FROM A LARGER KITCHEN THAT IS IN THE LONG TERM CARE PORTION OF THEIR BUILDING. THAT SECTION IS UNDER A SEPARATE LICENSE AND THEREFORE A SEPARATE SURVEY.

THIS ESTABLISHMENT HAS 5 SATELLITE KITCHENS WHERE THE FOOD IS PLATED AND SERVED TO THE RESIDENTS.

THIS ESTABLISHMENT ALSO HAS A CAFE ON THE FIRST FLOOR THAT IS OWNED BY AUBURN COURTS, BUT WAS NOT IN OPERATION DURING THIS INSPECTION.

ALL DISHES ARE TAKEN TO THE SAME KITCHEN FOOD COMES FROM.

INSPECTION CONDUCTED WITH BRANDON MUELLER (MDH) PRESENT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018231141 of 08/29/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
ERIN KRAMER

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us