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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3QQY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245604**
2.STATE VENDOR OR MEDICAID NO.
(L2) **422243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN MANOR**
(L4) **501 OAK STREET**
(L5) **CHASKA, MN** (L6) **55318**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245604

July 8, 2016

Mr. Rick Krant, Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Dear Mr. Krant:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 17, 2016 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of 61 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 6, 2016

Mr. Rick Krant, Administrator
Auburn Manor
501 Oak Street
Chaska, Minnesota 55318

RE: Project Number S5604026

Dear Mr. Krant:

On April 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 7, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 18, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 7, 2016, effective May 17, 2016 and therefore remedies outlined in our letter to you dated April 14, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245604	A. Building B. Wing	5/23/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 05/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) GL/mm	DATE 06/06/2016	SIGNATURE OF SURVEYOR 15507	DATE 05/23/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/7/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245604	A. Building 01 - MAIN BUILDING 01 B. Wing	5/18/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 05/17/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/17/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TLmm	DATE 06/06/2016	SIGNATURE OF SURVEYOR 34764	DATE 05/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245604 (Y1)	A. Building 02 - 2006 ADDITION B. Wing (Y2)	5/18/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** TLmm	**DATE** 06/06/2016	**SIGNATURE OF SURVEYOR** 34764	**DATE** 05/18/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/4/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3QQY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245604**
2.STATE VENDOR OR MEDICAID NO.
(L2) **422243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN MANOR**
(L4) **501 OAK STREET**
(L5) **CHASKA, MN** (L6) **55318**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/07/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Conrad Simba, HFE NEII — 04/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Mr. Rick Krant, Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: Project Number S5604026

Dear Mr. Krant:

On April 7, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 7, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET 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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		5/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 431	Continued From page 1 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were stored in a manner to ensure effectiveness and safety for residents on 2 of 3 medication carts (Blue Jay Lane, Yellowbird). An observation of storage of medications (meds) was conducted on the Yellowbird unit med cart on 4/7/16 at 10:15 a.m. with Trained medication assistant (TMA)-C. An opened vial of Lantus insulin for R59 was found with an open date of 3/7/16. R59 had diagnoses that included diabetes (a condition that causes a problem with a person's insulin and blood sugar levels). The current physician order indicated a 5:00 p.m. administration time. R59's care plan indicated staff should administer insulin "per MD order." TMA-C was questioned about the open date, and was not sure how long that med was good for. He called for licensed practical nurse (LPN)-B to make that determination. When shown a label on	F 431	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 in the Medicare and Medicaid Programs and, as required, are submitted as the facility□'s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. It is the intention of Auburn Manor to be compliant with the requirements at F 431. The surveyor discovered one dated vial of insulin that had been administered for two	

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F 431	Continued From page 2 the vial that indicated the insulin should be discarded after 28 days TMA-C acknowledged it was out of date. LPN-B arrived immediately - she verified the vial was out of date saying, "It was due [to be discarded] on 4/4/16 because that was 28 days after it was opened." When questioned further she acknowledged, "Yes, the resident was receiving out-of-date insulin on 4/5/16 and on 4/6/16." Documents regarding medication storage were reviewed. The Omnicare (pharmacy used by the facility) Recommended Minimum Medication Storage Parameters with revision date 9/29/15, indicated, "Based on America Diabetes Association guidelines...All [insulin] vials should be...discarded 28 days after opening.." The facility policy dated 1/1/13, additionally indicated meds should have an expiration date, not be retained longer than recommended by manufacturer or supplier guidelines, and, "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." Finally, the facility's "Insulin Storage Recommendations," revised 9/29/15, included Lantus, and identified the insulin expired 28 days for opened Lantus vials at room temperature. R59's insulin was stored in the med cart at room temperature. On 4/4/16, at 1:27 p.m. the Blue Jay Lane medication cart was observed with trained medication assistant (TMA)-A. A vial of Novolin R insulin was open, nearly full and not dated. The insulin vial had no label on it and indicated it had been taken out of the emergency (E) kit. The orange sticker on it said "discard after 28 days." TMA-A verified the insulin vial was opened, undated, almost full and contained no date when	F 431	days beyond the recommended discard date which is 28 days after it has been opened. The surveyor also noted an additional vial of insulin that had been removed from the facility's emergency kit and opened that was undated. Additionally, the surveyor identified a bottle of eye drops, and an opened undated Flovent Diskus. This finding is attributed to not following medication administration policies, procedures, and protocols and may have been identified sooner had there not been miscommunication between the facility and the consulting pharmacy regarding the cessation of the pharmacies quarterly medication storage audits. Facility staff took immediate action to remedy this finding by discarding the unlabeled medications. Replacements were ascertained. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility licensed staff and trained medication aides will review and discuss best practice strategies, policies, procedures for medication storage requirements and protocols, consistent with regulations and standards of nursing practice. 2. Ongoing: Bi-monthly medication audits will be conducted by nursing leadership to ensure that medications are correctly labeled and properly stored. Variations to the facility's medication labeling and	

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F 431	Continued From page 3 opened. TMA-A stated, "We do not know when this vial came out of the refrigerator." R3's name was handwritten on the vial. Review of R3's blood sugars in January 2016 indicated R3's blood sugars were over 350 needing sliding scale insulin. The INSULIN STORAGE RECOMMENDATIONS provided by the facility dated 2015, indicated Novolin R could be used for 42 days when stored up to 77 degrees. TMA-A also verified a bottle of eye drops (Xalatan) was opened, approximately 1/6 full and not dated. TMA-A stated she did not know how long the eye drops were effective. TMA-A stated, "The other eye drops in the drawer are dated except a couple of aqua tear bottles." Registered nurse (RN)-A walked up and when asked what the time frame was for the Xalatan's efficacy once opened, RN-A opened the TMA communication binder on the med cart to the sheet labeled "Recommended Minimum Medication Storage Parameters" (RMMSP). RN-A stated the RMMSP guidelines were from the pharmacy and indicated the Xalatan eye drops should be discarded after six weeks. RN-A stated since it was unknown when the bottle was opened staff would need to go by the date the bottle came up from pharmacy. RN-A verified the label on the bottle indicated the bottle had come up from pharmacy on 2/18/16. RN-A stated the insulins and eye drops were supposed to be dated after opening. On 4/4/16, at 3:00 p.m. RN-B stated eye drops were to be dated after opening and that pharmacy came out and completed medication cart audits. RN-B verified the vial of insulin and bottle of eye drops were opened, undated and	F 431	storage standards will be immediately corrected and reported on a quarterly basis to the Quality Assurance Committee for not less than 1 year of this plans date certain. Information obtained from this process will be integrated into Quality Assurance Initiatives and will be reviewed with recommendations for intervention made during the Quality Assurance Meetings.	

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F 431	Continued From page 4 should have been dated when opening. RN-B verified the insulin vial identified "sent 10-29-14" with no other date listed on the vial of insulin. On 4/4/16 at approximately 3:11 p.m. the director of nursing (DON) stated nurses and TMAs should follow the RMMSP guidelines provided by pharmacy. The DON also stated that eye drops and insulins, and all bottles of medications should be dated after opening. The DON stated the pharmacy was no longer doing medication cart audits. The last audit completed by the pharmacy had been completed in 12/15. The DON stated she would be completing medication cart audits, that she had the audit tool, but had not yet completed any medication cart audits. The DON stated, "Obviously we will have to set up some audits for medication storage." The DON further stated TMAs and not the nurses always gave the eye drops and that she would need to do some "education here." The DON stated the RMMSP sheet from pharmacy indicated Xalatan eye drops "discard unused portion 6 weeks after opening."The DON stated the Xalatan eye drops should have been dated when opened and that the last day the Xalatan eye drops should have been used for R3 was 3/31/16. Physician orders for R3 indicated the Xalatan drops were given 1 drop into both eyes at bedtime and that the order had started in 2013 for the diagnosis glaucoma. Physician orders for R3 also indicated that R3 was to be given 4 units of Novolog R insulin if her Blood Sugar was greater than 350. The DON stated she did not know why the insulin vial had been pulled from the emergency kit for R3 and not ordered from pharmacy but that she would check into the emergency kit procedure for removing medications.	F 431		

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F 431	Continued From page 5 On 4/7/16, at 8:53 a.m. during an observation of the medication cart on Blue Jay lane a Flovent diskus was open and undated with 49 of 60 doses left. TMA-B verified that no date was written on the diskus nor the foil package the diskus came in. The date printed on the label indicated the diskus came from the pharmacy on 3/16/16. R3's name was printed on it and indicated "One inhalation by mouth twice daily", for diagnosis of chronic obstructive pulmonary disease (COPD)/Asthma. TMA-B also verified the diskus foil package indicated "Date opened:_____" with no date completed when the diskus was opened. Expiration date on foil package indicated 8/17. TMA-B stated, "I would just use the flovent diskus until it was gone." LPN-A looked at the RMMSP guidelines dated last revised 3/31/14, which indicated the Flovent diskus was "good for 2 months." On 4/7/16 at 9:03 a.m. the DON stated since the Flovent diskus was opened and undated, staff would need to go by the date on the label when it came up from pharmacy. The DON wrote on the flovent diskus 3/16/16. The DON further stated all drugs needed to be dated when opened and that staff needed retraining. The Recommended Minimum Medication Storage Parameters sheet dated 9/29/15, provided by the facility indicated "Flovent Diskus... Date the Diskus when removed from the foil pouch and discard... 2 months ... after removal from foil pouch or after all blisters have been used (when dose indicator reads "0"), whichever comes first. The 2013, policy provided by the facility, indicated the facility should ensure that medications and biologicals: have not been retained longer than	F 431		

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F 431	Continued From page 6 recommended by manufacturer or supplier guidelines. Additionally, once any medication or biological package is opened, facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division, on April 04, 2016. At the time of this survey, Building 01 of Auburn Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2016

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 01 of 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. 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 61 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		5/17/16

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K 069 SS=D	Continued From page 2 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Findings include: During the facility tour and documentation review on 04/04/2016 between 1:30 PM and 4:00 PM, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The last documented inspection was done on 07/16/15. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 069	It is the policy, and intention, of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101(2000). On 4/4/16 during the facility tour and documentation review, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The last documented inspection was done on 07/16/15. Plan of Correction: 1. The facility's chief engineer is responsible for monitoring the kitchen hood system inspections and he has been re-educated on the necessity to track due dates for kitchen hood system inspections internally and not to rely solely on the contracted company responsible for conducting the inspection to schedule the inspections timely. 2. The facility's safety committee will be conducting bi-annual NFPA Life Safety Code Audit to ensure that the facility is compliant with the every 6 month kitchen hood inspection requirement on an ongoing basis.	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		5/17/16

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K 144 SS=C	Continued From page 3 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: During the facility tour and documentation review on 04/04/2016 between 1:30 PM and 4:00 PM, record review revealed the facility did not document the required cool down for the emergency generator. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 144	During the facility tour and documentation review on 04/04/2016, record review revealed the facility did not document the required cool down for the emergency generator. Plan of Correction: 1. The facility's chief engineer is responsible for documenting the required cool down for the emergency generator and has been re-educated oh the necessity to document the required cool down periods. The chief engineer has created a recording form and methodology to ensure the requirements are met. 2. The facility's safety committee will be conducting bi-annual NFPA Life Safety Code Audit to ensure that the facility is compliant with the documentation of emergency generator cool down requirements on an ongoing basis.	

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AUBURN MANOR	**501 OAK STREET 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) COMPLETION DATE
K 000	Continued From page 1	K 000		
	By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us>			
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency			
	Building 02 of Auburn Manor consists of 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. 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 61 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**04/04/2016**

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AUBURN MANOR	**501 OAK STREET CHASKA, MN 55318**

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K 144 SS=C	Continued From page 2 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: During the facility tour and documentation review on 04/04/2016 between 1:30 PM and 4:00 PM, record review revealed the facility did not document the required cool down for the emergency generator. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 144	During the facility tour and documentation review on 04/04/2016, record review revealed the facility did not document the required cool down for the emergency generator. Plan of Correction: 1. The facility's chief engineer is responsible for documenting the required cool down for the emergency generator and has been re-educated oh the necessity to document the required cool down periods. The chief engineer has created a recording form and methodology to ensure the requirements are met. 2. The facility's safety committee will be conducting bi-annual NFPA Life Safety Code Audit to ensure that the facility is compliant with the documentation of emergency generator cool down requirements on an ongoing basis.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS*otans*

Electronically delivered
April 14, 2016

Mr. Rick Krant, Administrator
Auburn Manor
501 Oak Street
Chaska, Minnesota 55318

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5604026

Dear Mr. Krant:

The above facility was surveyed on April 4, 2016 through April 7, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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 NLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact one of the following**:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00335	A. BUILDING: _____ B. WING _____	04/07/2016

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AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/4/16 through 4/7/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R12, R54, R71) had a two step tuberculin skin test (TST) administered 1 to 3 weeks after the first step.	21426	Corrected	5/17/16

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21426	Continued From page 3 Findings include: R12 was admitted to the facility on 10/10/14. The medical record indicated R12's first step TST was read on 10/13/14, and the second step TST was given on 10/17/14, four days after the last TST reading. R54 was admitted to the facility on 12/15/15, and the medical record indicated R54's first step TST was read on 12/19/15, and the second step TST was given on 12/23/15, four days after the last TST reading. R71 was admitted to the facility on 5/11/15. The facility accepted the results of R71's TST results done at another facility as documentation that R71 had both her first and second step TST done as required. However, R71's medical record indicated R71's first step TST was read on 4/23/15, and the second step TST was given on 4/28/15, five days after the last TST reading. During an interview on 4/6/16, at approximately 11:00 a.m. the director of nursing (DON) verified all residents received the two step TST upon admission. The DON explained the resident's TST results are put into their electronic computer system and she would print off the results of the mantoux's. The DON verified that R12, R54 and R71's second step was not given during the correct time period. During an interview on 4/7/16, at approximately 1:00 p.m. the infection control director explained the second step mantoux is given between 1-3 weeks after the first step. Later that day the DON was made aware that 3 of the resident received the second step TST too early.	21426		

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21426	Continued From page 4 The facility's policy titled Auburn Manor Resident Tuberculosis Program Policy indicated the purpose it to prevent transmission of Mycobacterium tuberculosis within the facility. The procedure indicated a "two step mantoux testing upon admission, if negative, second test to be administered one to three weeks later." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON), or designee could review and revise policies and procedures for TB surveillance. Appropriate staff could be educated on these policies an dprocedures. Audits could be conducted to ensure compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were stored in a manner to ensure effectiveness and safety for residents on 2 of 3 medication carts (Blue Jay Lane, Yellowbird). An observation of storage of medications (meds) was conducted on the Yellowbird unit med cart on	21610	Corrected	5/17/16

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21610	Continued From page 5 4/7/16 at 10:15 a.m. with Trained medication assistant (TMA)-C. An opened vial of Lantus insulin for R59 was found with an open date of 3/7/16. R59 had diagnoses that included diabetes (a condition that causes a problem with a person's insulin and blood sugar levels). The current physician order indicated a 5:00 p.m. administration time. R59's care plan indicated staff should administer insulin "per MD order." TMA-C was questioned about the open date, and was not sure how long that med was good for. He called for licensed practical nurse (LPN)-B to make that determination. When shown a label on the vial that indicated the insulin should be discarded after 28 days TMA-C acknowledged it was out of date. LPN-B arrived immediately - she verified the vial was out of date saying, "It was due [to be discarded] on 4/4/16 because that was 28 days after it was opened." When questioned further she acknowledged, "Yes, the resident was receiving out-of-date insulin on 4/5/16 and on 4/6/16." Documents regarding medication storage were reviewed. The Omnicare (pharmacy used by the facility) Recommended Minimum Medication Storage Parameters with revision date 9/29/15, indicated, "Based on America Diabetes Association guidelines...All [insulin] vials should be...discarded 28 days after opening.." The facility policy dated 1/1/13, additionally indicated meds should have an expiration date, not be retained longer than recommended by manufacturer or supplier guidelines, and, "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." Finally,	21610		

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21610	Continued From page 6	21610		

the facility's "Insulin Storage Recommendations," revised 9/29/15, included Lantus, and identified the insulin expired 28 days for opened Lantus vials at room temperature. R59's insulin was stored in the med cart at room temperature.

On 4/4/16, at 1:27 p.m. the Blue Jay Lane medication cart was observed with trained medication assistant (TMA)-A. A vial of Novolin R insulin was open, nearly full and not dated. The insulin vial had no label on it and indicated it had been taken out of the emergency (E) kit. The orange sticker on it said "discard after 28 days." TMA-A verified the insulin vial was opened, undated, almost full and contained no date when opened. TMA-A stated, "We do not know when this vial came out of the refrigerator." R3's name was handwritten on the vial. Review of R3's blood sugars in January 2016 indicated R3's blood sugars were over 350 needing sliding scale insulin.

The INSULIN STORAGE RECOMMENDATIONS provided by the facility dated 2015, indicated Novolin R could be used for 42 days when stored up to 77 degrees.

TMA-A also verified a bottle of eye drops (Xalatan) was opened, approximately 1/6 full and not dated. TMA-A stated she did not know how long the eye drops were effective. TMA-A stated, "The other eye drops in the drawer are dated except a couple of aqua tear bottles." Registered nurse (RN)-A walked up and when asked what the time frame was for the Xalatan's efficacy once opened, RN-A opened the TMA communication binder on the med cart to the sheet labeled "Recommended Minimum Medication Storage Parameters" (RMMSP). RN-A stated the RMMSP guidelines were from the pharmacy and indicated

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21610	Continued From page 7	21610		

the Xalatan eye drops should be discarded after six weeks. RN-A stated since it was unknown when the bottle was opened staff would need to go by the date the bottle came up from pharmacy. RN-A verified the label on the bottle indicated the bottle had come up from pharmacy on 2/18/16. RN-A stated the insulins and eye drops were supposed to be dated after opening.

On 4/4/16, at 3:00 p.m. RN-B stated eye drops were to be dated after opening and that pharmacy came out and completed medication cart audits. RN-B verified the vial of insulin and bottle of eye drops were opened, undated and should have been dated when opening. RN-B verified the insulin vial identified "sent 10-29-14" with no other date listed on the vial of insulin.

On 4/4/16 at approximately 3:11 p.m. the director of nursing (DON) stated nurses and TMAs should follow the RMMSP guidelines provided by pharmacy. The DON also stated that eye drops and insulins, and all bottles of medications should be dated after opening. The DON stated the pharmacy was no longer doing medication cart audits. The last audit completed by the pharmacy had been completed in 12/15. The DON stated she would be completing medication cart audits, that she had the audit tool, but had not yet completed any medication cart audits. The DON stated, "Obviously we will have to set up some audits for medication storage." The DON further stated TMAs and not the nurses always gave the eye drops and that she would need to do some "education here." The DON stated the RMMSP sheet from pharmacy indicated Xalatan eye drops "discard unused portion 6 weeks after opening."The DON stated the Xalatan eye drops should have been dated when opened and that the last day the Xalatan eye drops should have

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21610	Continued From page 8 been used for R3 was 3/31/16. Physician orders for R3 indicated the Xalatan drops were given 1 drop into both eyes at bedtime and that the order had started in 2013 for the diagnosis glaucoma. Physician orders for R3 also indicated that R3 was to be given 4 units of Novolog R insulin if her Blood Sugar was greater than 350. The DON stated she did not know why the insulin vial had been pulled from the emergency kit for R3 and not ordered from pharmacy but that she would check into the emergency kit procedure for removing medications. On 4/7/16, at 8:53 a.m. during an observation of the medication cart on Blue Jay lane a Flovent diskus was open and undated with 49 of 60 doses left. TMA-B verified that no date was written on the diskus nor the foil package the diskus came in. The date printed on the label indicated the diskus came from the pharmacy on 3/16/16. R3's name was printed on it and indicated "One inhalation by mouth twice daily", for diagnosis of chronic obstructive pulmonary disease (COPD)/Asthma. TMA-B also verified the diskus foil package indicated "Date opened:_____" with no date completed when the diskus was opened. Expiration date on foil package indicated 8/17. TMA-B stated, "I would just use the flovent diskus until it was gone." LPN-A looked at the RMMSP guidelines dated last revised 3/31/14, which indicated the Flovent diskus was "good for 2 months." On 4/7/16 at 9:03 a.m. the DON stated since the Flovent diskus was opened and undated, staff would need to go by the date on the label when it came up from pharmacy. The DON wrote on the flovent diskus 3/16/16. The DON further stated all drugs needed to be dated when opened and that staff needed retraining.	21610		

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21610	Continued From page 9 The Recommended Minimum Medication Storage Parameters sheet dated 9/29/15, provided by the facility indicated "Flovent Diskus... Date the Diskus when removed from the foil pouch and discard... 2 months ... after removal from foil pouch or after all blisters have been used (when dose indicator reads "0"), whichever comes first. The 2013, policy provided by the facility, indicated the facility should ensure that medications and biologicals: have not been retained longer than recommended by manufacturer or supplier guidelines. Additionally, once any medication or biological package is opened, facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		