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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3YBL

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 9/9/2013 (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NEII 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/06/2014 (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
09/12/2013
(L33)

DETERMINATION APPROVAL

CCN# 24-5604

At the time of the standard survey completed July 25, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On August 29, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS). The FMS revealed that the facility continued to not be in substantial compliance. The most serious deficiencies in the facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

As a result of the FMS, CMS imposed the following enforcement remedy:

Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2013 (42 CFR 488.417(b))

On September 9, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 25, 2013 and an FMS completed on August 29, 2013. Based on the PCR findings, it was determined that the facility had corrected the deficiencies issued pursuant to the standard survey completed on July 25, 2013 and the FMS completed on August 29, 2013, effective October 25, 2013.

As a result of the PCR findings, this Department recommended to the Region V Office of CMS the following actions related to the remedies. The CMS Region V Office concurred and authorized this Department to notify the Department of the following actions:

Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2013, be rescinded. (42 CFR 488.417(b))

Please refer to the CMS 2567B. Effective October 25, 2013, the facility is certified for 61 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5604 February 6, 2014

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

Effective October 25, 2013, the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 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.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

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

RE: Project Number S560423 and F5604023

Dear Mr. Krant:

On August 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

In addition, on August 29, 2013, A surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference the FMS revealed that your facility continues to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On September 12, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2013 (42 CFR 488.417(b))

On September 9, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 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 July 25, 2013 and an FMS completed on August 29, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2013 and FMS completed on August 29, 2013, effective October 25, 2013.

As a result of the PCR findings, this Department recommended to the Region V Office of CMS the following actions related to the remedies outlined in their letter of September 12, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2013, be rescinded.(42 CFR 488.417(b))

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5604r14.rtf

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building B. Wing	9/9/2013

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0327 Reg. # 483.25(j) LSC	09/03/2013	ID Prefix F0332 Reg. # 483.25(m)(1) LSC	09/03/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/MM	01/22/2014	22580	9/9/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/25/2013

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

Form Approved LSC
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building 01 - MAIN BUILDING 01 B. Wing	10/23/2013

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	09/03/2013	ID Prefix Reg. # NFPA 101 LSC K0069	09/03/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/MM	Date: 01/22/2014	Signature of Surveyor: 27200	Date: 10/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/23/2013		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building B. Wing 02 - 2006 ADDITION	10/23/2013

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).

(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	09/03/2013

Reviewed By State Agency	Reviewed By PS/MM	Date: 01/22/2014	Signature of Surveyor: 27200	Date: 10/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/23/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

FAX to:

Number of Pages: 18

CCN: 245604

Name: Auburn Manor

City, State: Chaska, MN

3 Month Date: 10/25/13

6 Month Date: 1/25/14

FMS Survey Date: 8/29/13

Fed Surveyor:

Contr Surveyor: 32812

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("W")	
F	K25	POC 10/25/13	Annotate 2567
F	K51	POC 10/25/13	Waiver form
F	K56	POC 10/25/13	AEM: W, TW
F	K69	POC ~~8~~ 8/30/13	ASPEN: IDR
			ASPEN: Update citations
			ASPEN: Enter POC dates
			Print Revised 2567
			Letter; in H; in AEM; lock
			Tell facility POC is OK
			Ask State to revisit
			AEM note

Approved: (YES) NO By: S. Pelinski Date: 9/30/13

Auburn
HOMES & SERVICES

SERVING SENIORS
IN THE SPIRIT OF CHRIST'S LOVE

501 North Oak Street • Chaska, MN 55318 • 952.448.9303 • www.auburnhomes.org

September 17, 2013

Mr. Stephen Pelinski, Branch Manager
Centers for Medicare and Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Mr. Pelinski,

Please accept the enclosed plan of correction, in response to the Federal Monitoring Life Safety Code Standard Survey completed at Auburn Manor, 501 North Oak Street, Chaska, Minnesota on August 29th, 2013, as our credible allegation of compliance.

Please contact me with any questions or concerns. I can be reached at 952-361-0340 or rkrant@auburnhomes.org.

Respectfully Submitted,

Rick Krant
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	**501 OAK STREET CHASKA, MN 55318**

RECEIVED
SEP 24 2013
CMS-V-DS&C

(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	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1992 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF Type of Structure: One story, Type II (000), 1992, unprotected noncombustible construction with six smoke compartments and a partial automatic (wet) sprinkler system. A Comparative Federal Monitoring Survey was conducted on 08/29/13, following a State Agency Annual Survey on 07/23/13 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Auburn Manor was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000	See attached.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/17/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 025	Continued From page 1 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers to resist the passage of smoke. The deficient practice affected three of six smoke compartments (including the Dining Area), staff and all residents. The facility has the capacity for 61 beds with a census of 55 the day of survey. Findings include: 1. Observation on 08/29/13 at 12:30 p.m. revealed an unsealed three inch overcut around a pipe penetration in the smoke barrier wall above the corridor smoke doors at the bathroom wall inside Room 1315. Interview on 08/29/13 at 12:30 p.m. with the facility Maintenance Supervisor revealed the facility was not aware of the unsealed overcut in the smoke barrier wall. 2. Observation on 08/29/13 at 12:40 p.m. revealed a two inch overcut around a pipe penetration in the smoke barrier wall above the ceiling inside Room 1301. Interview on 08/29/13 at 12:40 p.m. with the facility Maintenance Supervisor revealed the facility was not aware of the unsealed overcut in the smoke barrier wall. The census of 55 was verified by the	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 025	Continued From page 2 Administrator on 08/29/13. The finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit interview on 08/29/13. Actual NFPA Standard: NFPA 101, 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: 1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Actual NFPA Standard: NFPA 101, 8.3.6.2. Openings occurring at points where floors or	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 025	Continued From page 3 smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. Actual NFPA Standard: NFPA 101, 8.3.2*. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 051	Continued From page 4 tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to meet the requirements for the fire alarm system. The deficient practice affected six of six smoke compartments, staff, and all residents. The facility has the capacity for 61 beds with a census of 55 the day of survey. Findings include: 1. Record review of the facility's smoke detectors testing reports for the year prior to the survey on 08/29/13 at 11:15 a.m. revealed the sensitivity test of the smoke detectors was past due. The last sensitivity test was performed on 05/12/2010. The most recent fire alarm inspection report (dated 05/08/13) indicated a faulty smoke detector was found in the hallway. Interview on 08/29/13 at 11:15 a.m. with the Maintenance Supervisor revealed the facility was unaware the sensitivity test was past due.	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 051	Continued From page 5 2. Observation on 08/29/13 at 2:38 p.m. revealed after the Maintenance Supervisor activated the fire alarm system in the nursing home, the following components of the fire alarm system did not function in the nursing home: a. Fire alarm A/V notification devices located in the Chapel and Fireside Room did not operate. b. Fire alarm A/V notification devices located in the Corridor by the Restrooms and Chapel did not operate. c. Magnetic hold open devices installed at the fire doors that separate the nursing home from the assisted living facility did not release the doors. d. Magnetic hold open devices installed Corridor doors to the Chapel, Fireside Room, and Dining Room did not release the doors. Interview on 08/29/13 at 2:38 p.m. with the Maintenance Supervisor revealed the area is controlled by a separate fire alarm system installed in the assisted living facility. According to the Maintenance Supervisor the facility was not aware the 400 Hall fire alarm components were required to be controlled by the fire alarm installed in the nursing home. 3. Observation on 08/29/13 at 3:00 p.m. revealed after the Maintenance Supervisor disconnected primary power to the fire alarm system and " A/C Power Loss " was indicated at the fire alarm control panel, two of six magnetic locking devices failed to unlock at the exit doors by the employee entrance and the 1100 Wing. Interview on 08/29/13 at 3:00 p.m. with the Maintenance Supervisor revealed the facility was not aware the magnetic locking devices were not	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 051	Continued From page 6 unlocking upon loss of primary power to the fire alarm system. The census of 55 was verified by the Administrator on 08/29/13. The finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit interview on 08/29/13. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. Actual NFPA Standard: NFPA 72, 3-9.7.1. Any device or system intended to actuate the locking or unlocking of exits shall be connected to the fire alarm system serving the protected premises. Actual NFPA Standard: NFPA 72, 3-9.7.2. All exits connected in accordance with 3-9.7.1 shall unlock upon receipt of any fire alarm signal by means of the fire alarm system serving the protected premises. Actual NFPA Standard: NFPA 72, 3-9.7.3. All exits connected in accordance with 3-9.7.1 shall unlock upon loss of the primary power to the fire alarm system serving the protected premises. The secondary power supply shall not be utilized to maintain these doors in the locked condition. Actual NFPA Standard: NFPA 72, 7-3.2.1*. Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 051	Continued From page 7 extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Actual NFPA Standard: NFPA 101, 9.6.5.2. Where required by another section of this Code, the following functions shall be actuated by the	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 051	Continued From page 8 complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors	K 051		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to meet the requirements for the sprinkler system. The deficient practice affected six of six smoke compartments, staff, and all residents. The facility has the capacity for 61 beds with a census of 55 the day of survey. Findings Include: Observation on 08/29/13 starting at 1:30 p.m.	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 056	Continued From page 9 revealed the facility failed to provide sprinkler coverage in resident room closets throughout the facility. The closets were approximately four feet by three feet in size and were separated from the resident rooms with floor to ceiling walls and doors. Interview on 08/29/13 at 1:30 p.m. with the Maintenance Supervisor revealed the facility was not aware sprinkler coverage was required in the closets. The census of 55 was verified by the Administrator on 08/29/13. The finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit interview on 08/29/13. Actual NFPA Standard: NFPA 13, 1-6.1. A building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. Exception: This requirement shall not apply where specific sections of this standard permit the omission of sprinklers. CMS S&C Letter: S&C-13-55-LSC, Q6: Sprinklers are required in all closets in a nursing home regardless of the size of the closets.	K 056		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire suppression system in	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2013**

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
K 069	Continued From page 10 the Kitchen. The deficient practice affected one of six smoke compartments (including the Dining area), staff, and all residents. The facility has the capacity for 61 beds with a census of 55 the day of survey. Findings Include: Record review of the facility's kitchen fire suppression system inspection reports for the year prior to the survey on 08/29/13 at 11:55 a.m. revealed the facility failed to perform the six month inspections of the fire-extinguishing system and exhaust hood serving the cooking equipment. Based on records available for review during the survey, inspections were conducted on 07/23/13, 04/05/12, and 04/15/11. Interview on 08/29/13 at 11:55 a.m. with the Maintenance Supervisor revealed the facility was aware of the deficient practice and is now conducting the six month inspections as required. The census of 55 was verified by the Administrator on 08/29/13. The finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit interview on 08/29/13. Actual NFPA Standard:NFPA 96, 8-2*: An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. A-8-2	K 069		

501 North Oak Street • Chaska, MN 55318 • 952.448.9303 • www.auburnhomes.org

DATE: September 17, 2013

SUBJECT: Plan of Correction for the Life Safety Federal Monitoring Survey (FMS) completed at Auburn Manor in Chaska, 501 North Oak Street, Chaska, Minnesota on August 29, 2013 by a surveyor representing the office of the Centers for Medicare and Medicaid Services.

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 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities and as outlined in NFPA 101(2000). This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. 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.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor has smoke barriers constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. It is the intention of the facility to maintain smoke barriers to resist the passage of smoke.

On 8/29/2013, during a Comparative Federal Monitoring Survey, the following concerns were noted:

1. An unsealed three inch overcut around a pipe penetration in the smoke barrier wall above the corridor smoke doors at the bathroom wall inside room 1315 was noted.
2. A Two inch overcut around a pipe penetration in the smoke barrier wall above the ceiling inside room 1301 was noted.

Plan of Correction:

1. *The maintenance supervisor for the facility will seal the overcuts identified in compliance with NFPA Standards. The facility's maintenance department will be responsible for conducting quarterly fire and safety hazard inspections which will include actual or potentials for a breach in the facility's smoke and fire barriers. Immediate remedial measures will be implemented whenever a problem is identified.*

The quality assurance committee will monitor fire and safety hazard inspection results for compliance and make recommendations, where appropriate, to facility administration.

Timeline for Correction: *Date of completion not to exceed October 25, 2013.*

K 051 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor has a fire alarm system with approved components, devices, and equipment installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection and extinguishing system operation. It is the intention of the facility to be in compliance with all testing and maintenance requirements for the facility's fire alarm system.

On 8/29/2013, during a Comparative Federal Monitoring Survey, the following concerns were noted:

1. Record review of the facility's smoke detectors testing reports for the year prior to the survey revealed that the sensitivity test of one of the smoke detectors was past due.

Plan of Correction:

1. *The facility's maintenance department will be responsible for ensuring compliance with the sensitivity tests of the smoke detectors requiring said monitoring/testing. The facility's maintenance department will be responsible for conducting quarterly fire and safety hazard inspections which will include timely sensitivity testing of smoke detectors as required by NFPA 72. Immediate remedial measures will be implemented whenever a problem is identified. The quality assurance committee will monitor fire and safety hazard inspection results for compliance and make recommendations, where appropriate, to facility administration.*

Timeline for Correction: *Date of completion not to exceed October 25, 2013.*

2. Upon activation of the fire alarm system in the nursing home, the following concerns were noted by the surveyor:
    a. The fire alarm A/V notification devices located in the chapel and Fireside Room did not operate.
    b. The fire alarm A/V notification devices located in the corridor by the restrooms and chapel did not operate.
    c. Magnetic hold open devices installed at the fire doors that separate the nursing home from the assisted living facility did not release the doors.
    d. Magnetic hold open devices installed corridor doors to the chapel, Fireside Room, and dining room did not release the doors.

All of the areas noted above are controlled by a separate fire alarm system installed in the joining assisted living facility. The surveyor noted that the fire alarm components in the 400 Hall were required to be controlled by the fire alarm installed in the nursing home.

Plan of Correction:

1. *The maintenance supervisor for the facility has contacted the facility's fire alarm system company in order to coordinate the reprograming of the fire alarm system so that it interfaces with the above noted areas of concern. All areas of concern, noted above, will be dual controlled by both the nursing home and assisted living fire alarm systems. Appropriate functioning of the aforementioned fire alarm components will be monitored during the routine monthly fire drills. The facility's maintenance department will be responsible for conducting monthly fire drills and subsequent monitoring of the aforementioned fire alarm components to ensure appropriate function. Immediate remedial measures will be implemented whenever a problem is identified. The quality assurance committee will monitor fire drills and fire alarm system function results for compliance and make recommendations, where appropriate, to facility administration.*

Timeline for Correction: *Date of completion not to exceed October 25, 2013.*

3. After the primary power to the fire alarm system was disconnected and the fire alarm control panel indicated "A/C Power Loss," two of six magnetic locking devices did not unlock the exit doors at the employee entrance and at the 1100 wing.

Plan of Correction:

1. *The locking devices at the aforementioned doors will be replaced. The new locking devices will unlock upon receipt of any fire alarm signal by means of the fire alarm system serving the protected premises. These devices will unlock upon loss of the primary power to the fire alarm system serving the protected premises. Appropriate functioning of the aforementioned fire alarm components will be monitored during the routine monthly fire drills. The facility's maintenance department will be responsible for conducting monthly fire drills and subsequent monitoring of the aforementioned fire alarm components to ensure appropriate function. Immediate remedial measures will be implemented whenever a problem is identified. The quality assurance committee will monitor fire drills and fire alarm system function results for compliance and make recommendations, where appropriate, to facility administration.*

Timeline for Correction: *Date of completion not to exceed October 25, 2013.*

K 054 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor does have an automatic sprinkler system which was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is reliable, adequate water supply for the system. The sprinkler system is equipped with water flow and tamper switches, which are electronically connected to the building fire alarm system.

Prior to the FMS, Auburn Manor had been informed that the existing sprinkler configuration in each resident room was sufficient to provide adequate fire suppression coverage of the resident closets. The surveyor referenced CMS S&C Letter: S&C-13-55-LSC, Q6, dated August 16, 2013, in the issuance of this deficiency. At this time, the facility has been notified that all resident closets, throughout the facility, require separate sprinkler heads.

Plan of Correction:

1. *The facility has contracted with an approved fire suppression company which services and maintains the existing fire suppression system to install the required sprinkler heads in resident closets throughout the facility.*

Timeline for Correction: *Date of completion not to exceed October 25, 2013.*

K 069 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor intends to protect its cooking facilities in accordance with 9.2.3 19.3.2.6, NFPA 96 which addresses the cleaning and inspection of the kitchen hood system protecting the cooking appliances. NFPA 96 8-3.1 table 8-3.1 states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semi-annually by a properly trained, qualified, and certified company or person.

On 7/23/2013, during a Life Safety Code Survey conducted by the state fire marshal's office, the following concern was noted:

During the review of all documentation for the kitchen hood ventilation system inspection reports, it was determined that more than 6 months had elapsed since the last time that the kitchen hood/ventilation system had been completely cleaned and professionally inspected. The qualified technician arrived during the 7/23/13 survey to complete the cleaning and inspection of the kitchen hood/ventilation system. It is the facility's belief that it was in compliance on 8/29/13 during the FMS when this deficiency was issued again.

Plan of Correction:

1. *As noted above, the qualified technician arrived during the initial state fire marshal's office survey to complete the cleaning and inspection of the kitchen hood/ventilation system. This process was completed the day of the survey on 7/23/13.*
2. *The maintenance supervisor for the facility will monitor the kitchen hood/ventilation system cleaning and inspection schedule to ensure semi-annual cleaning and inspection of the named equipment. In the event that scheduling and/or performance of required service becomes problematic, the maintenance supervisor will notify the administrator. Compliance with the semi-annual cleaning and inspection requirement will be monitored as part of the facility's safety committee functions. This monitoring will be coordinated to correspond with the facility's monthly fire drill schedule. The quality assurance committee will monitor fire and safety hazard inspection results, for compliance, and make recommendations, when appropriate, to facility administration on an as needed and quarterly basis.*

Timeline for Correction: *Completed.*

Respectfully Submitted,

Rick Krant
Administrator

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building B. Wing **01 - MAIN BUILDING 01**	10/23/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/25/2013**	ID Prefix	Correction Completed **10/25/2013**	ID Prefix	Correction Completed **10/25/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0025		LSC K0051		LSC K0056	
ID Prefix	Correction Completed **08/30/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0069		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/22/2014	27200	10/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/29/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3YBL

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 **07/25/2013** (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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Alberts, HFE NE II 08/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/10/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 9/12/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5604

At the time of the standard survey completed July 25, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5193

August 12, 2013

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

RE: Project Number S5604023

Dear Mr. Krant:

On July 25, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Gayle Lantto
Minnesota Department of Health
P.Box 64900
Saint Paul Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 3, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 25, 2013 (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 January 25, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

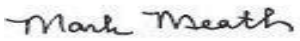
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5604s13.rtf

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 _____	07/25/2013

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. 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 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	(See Attached) RECEIVED AUG 26 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess fluid intake for 1 of 1 resident (R25) reviewed for hydration. Findings include: R25 lacked an assessment of hydration needs to determine adequacy of fluid intake. R25 was observed on 7/23/13, at 1:24 p.m. to have dry scaly lips and thick saliva. The following day at 7:30 a.m. the resident was again observed, however, her lips were not chapped or dry looking and no thick saliva was present. She had a thermal cup with straw on the bedside table; the	F 327		9-3-13

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

Administrator 8/23/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 327	Continued From page 1 cup was almost empty. When asked, R25 stated that she knew she needed to drink fluids but did not really like to drink water. At 8:30 a.m. R25 was having her breakfast in the dining room. She had consumed her breakfast of hot cereal, toast, and orange juice, and was sipping on decaffeinated coffee. A glass of milk was set at her place but was still full. No water was offered at breakfast. Review of the medical record revealed that R25 used an indwelling catheter to pass urine, she had frequent urinary tract infections (UTI) and had decreased cognitive function related to dementia. The medical administration record (MAR) instructed staff to encourage fluids for R25, although specific amounts or times were not indicated. A registered nurse (RN)-D was interviewed on 7/24/13, at 12:45 p.m. She explained that specific times and amount of fluids were not identified on the MAR, only an order to "encourage fluids," and the amounts consumed would not be recorded without a specific order as such. A nursing assistant (NA)-A was interviewed on 7/24/13, at 1:00 p.m.. She explained that she recorded meal intakes for each person cared for and entered the information into the Point of Care documentation program. She offered R25 extra fluids on occasion, but was unaware of any particular plan for fluids for the resident. The Neighborhood Book was reviewed on 7/24/13. The book contained information for the NA's regarding resident care specifics. The book lacked evidence of a care plan to encourage fluids between meals for R25. The initial nutritional assessment dated 8/15/12,	F 327		

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F 327	Continued From page 2 indicated that R25 required 1500-1650 cubic centimeters (cc) of fluids daily to meet her needs. Intake of food was documented as 76-100%. Intake of fluids was not documented; the assessment section for fluid intake was blank. The most recent registered dietitian (RD) progress note dated 8/30/12, indicated an intake of 50-100% of most meals with fair to good fluids per food record. The recommendation was to encourage fluid intake throughout the day due to recent UTI. Subsequent dietary notes lacked an assessment of actual fluids consumed to determine if R25 was actually meeting her estimated needs. The director of dietary services (DDS) was interview on 7/24/13, at 1:40 p.m.. She explained that the nursing staff were to record the amount of food and fluids consumed for each resident, and record the amounts in the computer medical record. They were to record the fluids given with meals and the fluids given with medications and snacks. The DDS explained that, although fluid needs were calculated, it was not a regular practice to review intakes of fluids to determine if residents were meeting their goals. The DDS did explain that R25 had approximately 2600 cc of fluids offered to her, but was not sure how much was actually consumed. The fluid intake record for R25 was reviewed and found to be missing entries. Some days had only two entries for meals and between meal fluids were not documented. The Food and Fluid Intake policy dated 4/27/12, indicated the facility would be aware of the nutritional needs of each resident based upon the comprehensive assessment, and record food and fluid intake at mealtimes when resident fluid	F 327		

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F 327	Continued From page 3 intake concerns have been noted. The Nutritional Adequacy for Residents policy (undated) indicated that food intake information would be analyzed and compared to calculated needs.	F 327		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of fewer than 5% for 3 of 4 residents (R62, R20, R4) observed during medication administration. The facility's medication error rate was 17.8%. Findings include: WRONG TIME: R4 was given Aspirin (anticoagulant) and Klor Con (potassium supplement) one hour before breakfast. These medications were to be given with food. On 7/23/13, at 8:04 a.m. trained medication aide (TMA)-A put 12 oral medications into a medication cup which included aspirin 81 milligrams (mg) and Klor Con 10 mEq (milli equivalence). The medication bottle label and the computerized medication administration form indicated the aspirin and Klor Con were to be given with food. The TMA added one to two small teaspoons of applesauce into the medication cup	F 332		9-3-13

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F 332	Continued From page 4 and entered R4's room. Without chewing any medication, R4 swallowed all the medications whole. The resident was not provided food until 9:00 a.m. when she was served the breakfast meal. R4 had a diagnoses of long term use of anticoagulant/ASA (aspirin) and hypopotassium (low potassium). The computerized physician order indicated on 12/21/12, chewable aspirin 81 mg was ordered and to be given with food, once a daily at 8:00 a.m. On 11/7/12, the Klor Con 10 mEq was ordered and was to be given twice a day at 8:00 a.m. and 1800 (6:00 p.m.) with food. The computerized medication record indicated the special instructions for the aspirin 81 mg and the Klor Con 10 mEq was "Give with food." On 7/23/13, at 9:40 a.m. TMA-A was interviewed and verified the aspirin and Klor Con were ordered to be given with food. The TMA confirmed R4 was not given anything to eat prior to the medication administration. On 7/23/13, at 1:38 p.m. the neighborhood coordinator (NC) was interviewed. The NC stated the facility had snacks available should a resident to have food with medication. The NC stated staff should have obtained a snack, particularly if a resident had to wait for the next meal. The NC verified the staff should have followed physician orders and any special instructions for medication administration. On 7/24/13, at 8:04 a.m. a telephone interview was done with the consultant pharmacist (CP). The CP was informed R4 was given aspirin 81 mg and the Klor Con 10 mEq one hour before the breakfast meal. The CP stated the aspirin was	F 332		

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F 332	Continued From page 5 enteric coated so it may not cause gastric upset, but explained that taking Klor Con could contribute to gastric upset. When informed R4's physician ordered the aspirin and Klor Con were to be given with food, the CP stated then the medication should have been administered with food. On 7/24/13, at 9:11 a.m. the pharmacy nurse consultant (PNC) was interviewed via the telephone. The PNC was informed R4's aspirin and Klor Con were to be given with food, but the resident instead was administered the medication and then did not eat until and hour later. The PNC stated staff had been educated regarding the issue, and only 15 minutes should have lapsed between the administration and when food was offered. The PNC verified when a physician ordered a medication was to be given with food, staff were to follow those orders. WRONG DOSE: R4 had the diagnosis of constipation and was given the wrong dose of polyethylene glycol (for Miralax, a laxative solution). On 7/23/13, at 8:04 a.m. the computerized medication administration form and the Miralax label indicated the resident was to have 8.5 grams (gr) everyday. The TMA-A measured one even teaspoon of Miralax into a six ounce glass and then added approximately one and one half inches (approximately 1/4 cup) of water to the Miralax glass. The TMA brought the Miralax into the resident's room and the resident drank the solution. No other water was added to the Miralax solution. The computerized physician orders were reviewed and indicated on 11/8/12, polyethylene glycol 17 Gm 1/2 scoop to be given everyday at	F 332		

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F 332	Continued From page 6 8:00 a.m. On 7/23/13, at 11:05 a.m. TMA-A was interviewed and asked how much 1/2 scoop or 8.5 Gm of Miralax was. The TMA stated he did not know. On 7/23/13, at 11:07 a.m. a registered nurse (RN)-A was interviewed. When asked how Miralax was to be measured, RN-A stated the caps on the Miralax containers were used to measure the amount of Miralax to be given. RN-A was informed TMA-A gave R4 one level teaspoon of Miralax in approximately 1/4 cup of water and gave it to the resident. On 7/23/13, at 1:11 p.m. RN-A stated she looked up the Miralax dosage and found that 17 Gm of Miralax was two tablespoons, so 8.5 Gr would have been one tablespoon. On 7/23/13, at 1:22 p.m. the NC was interviewed and stated the Miralax information was reviewed. The NC stated the physician was contacted and the Miralax order was clarified and the correct dosage measurement was added. The NC stated the TMA was educated on the correct dose. The facility policy and procedure #6.0 General Dose Preparation and Medication Administration (revision date 1/1/13), indicated #4.1 Staff should verify each time a medication was administered that it was to be administered to the correct resident, the correct medication, the correct route, the correct rate, the correct dose, and at the correct time. MISSED DOSE/MEDICATION SUPPLY NOT AVAILABLE: R20's supply of Ferrous Gluconate (an iron replacement) was unavailable and the resident missed the morning dose.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 7 On 7/23/13, at 8:17 a.m. TMA-A was preparing R20's medications for the morning medication pass. The TMA was unable to find the Ferrous Gluconate 324 mg (milligrams) tablets in the medication cart and RN-A was notified to check the medication room supply for the medication. TMA-A reviewed the medication order log which indicated the Ferrous Gluconate had been ordered on 7/22/13, but had not been delivered. R20 had a diagnosis of iron deficient anemia and was on Ferrous Gluconate for iron replacement therapy. The computerized physician orders indicated the Ferrous Gluconate 324 mg given twice daily at 9:00 a.m. and 5:30 p.m. R20's hemoglobin (iron in red blood cells that is vital to transport oxygen and carbon dioxide in the blood) levels were reviewed. Normal hemoglobin level range were noted as 11.8 to 15.5 g/dL (grams per deciliter) and the residents were low as follows: 1) 1/16/13 - 8.7; 2) 1/21/13 - 9.8; 3) 2/27/13 - 9.6; and 4) 6/19/13 - 9.4 g/dL. On 7/23/13, at 8:33 a.m. RN-A reported there was no available supply of Ferrous Gluconate for R20. At 8:57 a.m. She said the pharmacy was notified, and she was told the medication was ordered too soon, but it would be sent that day around 4:00 or 5:00 p.m. RN-A explained medication would only come sooner than that if it was an emergency or immediate order. On 7/23/13, at 8:38 a.m. TMA-A was asked to explain the medication order system. The TMA said they entered the resident name and medication onto the pharmacy fax sheet and faxed the form to the pharmacy at the end of the	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 8 shift. On 7/23/13, at 9:20 a.m. RN-A stated the TMAs were responsible to order what they dispensed to the resident. The RN stated the TMAs were suppose to gauge the need to refill and if the medication had a four day or less supply, then they should have sent a reorder form to the pharmacy. On 7/24/13, at 8:08 a.m. the CP was interviewed. The CP was informed on 7/23/13, the facility did not have a supply of R20's Ferrous Gluconate and the pharmacy would not deliver a supply until around 4:00 p.m. on 7/23/13. The GP was also informed R20 was to have Ferrous Gluconate twice a day at 9:00 a.m. and at 5:30 p.m., however, since there was not a supply in the facility R20 would miss a dose. The CP then confirmed R20 would then miss a dose of Ferrous Gluconate. R62 did not receive the cranberry tablets for prevention of urinary tract infections (UTI). On 7/22/13, at 7:33 p.m. per licensed practical nurse (LPN)-B was preparing R62's evening medications for administration. As the LPN prepared the medications, the LPN stated the supply of cranberry tablets was not in the medication cart nor in the medication room. Review of the pharmacy order form indicated the order was last filled on 4/21/13. The LPN stated the cranberry tablet was unavailable for R62 for the evening medication pass. On 7/22/13, at 7:44 p.m. RN-B also checked the medication cart and medication room for a supply of cranberry tablets for R62. The RN stated the	F 332		

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 _____	07/25/2013

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 332	Continued From page 9 pharmacy was notified and the cranberry tablets will be available on 7/23/13. The resident missed the 7/22/13 evening dose of cranberry tablets. Review of the computerized physician orders indicated the cranberry tablets 400 mg were ordered on 11/20/12, given for UTI prevention/treatment and were to be given at 9:00 p.m. On 7/24/13, at 9:11 a.m. the PNC was interviewed via the telephone and informed the medication supplies were unavailable for the R20 and R62. When the PNC was asked if the facility had reported any on going concerns, the NC stated that had not been a concern and had not been mentioned lately. The PNC stated she observed a random medication pass quarterly and the lack of medication supplies were not something she had seen. The facility policy and procedure #7.0 Medication Shortages/Unavailable Medications (revision date 1/1/13) indicted if a medication shortage was discovered during normal pharmacy hours, the facility should call the pharmacy to determine the status of the order. If not ordered, nurse should have ordered the medication for the next scheduled deliver. If the next available delivery caused delay or a missed dose in the resident's medication schedule, the nurse should have obtained the mediation from the emergency medication supply. If the mediation was not available in the Emergency Medication Supply, the nurse should have called the pharmacist to manage a plan of action. If an emergency delivery was unavailable, the facility nurse should have contacted the attending physician and obtain orders.	F 332		

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 _____	07/25/2013

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

501 North Oak Street • Chaska, MN 55318 • 952.448.9303 • www.auburnhomes.org

DATE: August 23, 2013

SUBJECT: Plan of Correction for the annual Certification Standard Survey completed at Auburn Manor, 501 North Oak Street, Chaska, Minnesota by the Minnesota Department of Health and Public Safety on July 25, 2013.

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.

F 327
SS=D
483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION

Auburn Manor provides each resident with sufficient fluid intake to maintain proper hydration and health. According to the Centers for Medicare and Medicaid Services, "sufficient fluid" means the amount of fluid needed to prevent dehydration and maintain health.

On 7/23/13, at 1:24 p.m., a surveyor noted that "R25 had dry scaly lips and thick saliva. The following day at 7:30 a.m. her lips were not chapped or dry looking and no thick saliva was present." She had water in a thermal cup with a straw that was available to her. The resident acknowledged that she was aware that she needed to drink fluids but did not really like water. The resident had not expressed her dislike of water to facility staff prior to this incident. Later that morning the resident had a full array of fluids available to her at breakfast including orange juice, milk, and decaffeinated coffee. The surveyor noted that water was not offered during the meal. However, earlier that morning the resident told the surveyor that she did not like water.

R25 had a history of recurrent Urinary Tract Infection (UTI). In response, nursing staff initiated a nursing order to encourage fluids for R25. This nursing order was communicated via the Medication Administration Record (MAR). Amounts of fluids or times consumed were not intended to be part of the nursing order.

The facility completes a comprehensive nutritional assessment, including hydration needs and status, at the time of admission and annually thereafter; and if there has been a significant change in the residents' status or if fluid intake concerns have been noted. In this particular instance, the surveyor's observations were isolated. Although the resident does have some signs of cognitive impairment, she had acknowledged her understanding of the need to drink extra fluids to the surveyor. The resident did not exhibit any additional signs of dehydration such as dry mucus

membranes, cracked lips, poor skin turgor, thirst, fever, or lab values that would be indicative of dehydration. The nursing order to encourage fluids was initiated as a result of R25's UTI history, not because of any identified pre-existing risk for dehydration. Additionally, the consulting registered dietician had made a recommendation on 8/30/12 to encourage fluid intake throughout the day due to a recent UTI.

Inconsistent staff communication and documentation of fluids consumed for R25 may have been contributing factors to the survey team's findings. In response, the facility has re-educated the staff on the necessity to encourage fluids to R25 throughout the day and consistently record fluids consumed during mealtimes. The Neighborhood Book has been updated to include encouraging fluids to R25.

This plan and response to CMS-2567 regarding F 327 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. To ensure ongoing hydration of residents, the facility will identify the baseline daily fluids needs of residents at the time of their initial comprehensive assessment and annually thereafter. Facility staff will compare documented fluid intake at mealtime to the identified resident daily fluids needs periodically, and at a minimum, quarterly during the resident's quarterly assessment. The facility acknowledges that the amount of fluid needed for each resident is specific and will fluctuate as the resident's condition fluctuates.
2. Facility staff responsible for documenting fluid intake at meals will be re-educated on the necessity for consistent documentation practices.
3. Facility staff will review techniques to enhance fluid intake for those 'at need' residents who have been identified. For example, keeping fluids next to the resident at all times, assisting and/or cuing residents to drink, and offering alternative fluids such as popsicles, gelatin, and other similar non-liquid foods.
4. Those residents identified as requiring enhanced fluid intake will be noted in the MAR & Neighborhood Book to enhance communication among facility care staff.
5. Applicable facility policy and procedures will be reviewed and revised to reflect the aforementioned responses.
6. *Ongoing:* Quarterly random audits of residents' hydration needs and resultant plan of care, including the documentation of mealtime fluid consumption, will be conducted. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed September 3, 2013.

F 332
SS=E
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

It is the intention of Auburn Manor to ensure that residents are free of medication errors to the extent possible. The facility provides medication administration in accordance with accepted protocols and practices consistent with accepted standards of nursing practice.

During the survey, three residents were observed to have received medications at either the wrong time, the wrong dose, or have had missed doses because the medication supply was not available.

Upon facility analysis of these survey findings, it was determined that contributing factors to these findings included isolated individual variances from the accepted medication administration standards of practice as outlined in the facility's pharmacy policies and procedures. In response, the individuals involved have been counseled and re-educated on facility policy and procedure and acceptable medication administration practices.

In all examples cited, no significant medication errors were noted and there were no negative resident outcomes.

This plan and response to CMS-2567 regarding F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE is written solely to maintain certification in the Medicare and Medicaid Programs. This written response does not constitute an admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

Facility Wide Response Affecting All Residents:

1. To ensure medication administration practices consistent with time parameters as ordered, facility staff responsible for medication administration will be re-educated on the necessity to follow medication orders as written. Medications that are to be given with food will correlate with meal times to the extent possible. If a meal is not immediately available, a significant snack consistent with the resident's dietary plan will be administered with the medication.
2. To ensure medication administration practices consistent with dosing as ordered, facility staff responsible for medication administration will be re-educated on the necessity to ensure that the medication order/directions on the medication label are consistent with the medication order as reflected on the Medication Administration Record (MAR) and with the original prescriber's order. Order discrepancies will be brought to the attention of the nurse in charge. Nurses will be responsible for validating the order with the pharmacy and/or the prescriber for verification, clarification, or a change in the original order.

3. To avoid missed medications because of the unavailability of the medication, staff responsible for re-ordering of medication supplies will be re-educated on the facility's protocol as to when to re-order medications that are running low. Additionally, facility staff will be re-educated on reordering of medications utilizing the facility-adopted on-line ordering system, rather than relying on the antiquated system of ordering medications via the facsimile machine. Facility staff responsible for medication administration will also be re-educated on the facility's Medication Shortages/Unavailable Medications Policy and Procedure. All medication supply shortages will be brought to the attention of the nurse in charge.
4. *Ongoing:* Random medication administration record audits of a selected resident sample will occur on a quarterly basis. The audits will focus on adherence to the facility's medication administration policies and procedures. The Pharmacy Nurse Consultant (PNC) will conduct quarterly medication administration audits for compliance purposes. Medication errors will be investigated and tracked in an effort to track potential patterns and identify potentially modifiable contributing factors. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed September 3, 2013.

Respectfully Submitted,

Rick Krant
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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
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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, 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 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	(see Attached) RECEIVED AUG 26 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 8-26-13	

DC: 09.03.2013

EXIT: 07.25.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/23/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Auburn Manor is a 1-story building with no basement that was constructed at 3 different times. The original building was constructed in 1988 and was determined to be of Type II(111) construction. In 1992, an addition was constructed that was determined to be of Type II(111). In 2006 another addition was added and was determined to be of Type II(111) construction. Because the original building and the additions do not meet the construction type allowed for an existing building, the facility was surveyed as two buildings. 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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
K 000	Continued From page 2 by 2-hour fire walls and opening protectives consisting of labeled, 90-minute fire door assemblies. These fire doors are self-closing and positive latching. The facility has a capacity of 61 beds and had a census of 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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
K 056	Continued From page 3 and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 07/23/2013, observations reveled that the spare sprinkler head box was not equipped with at least 2 of every type of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the same type as the ones located in the lower level Mechanical room where the main sprinkler riser and spare sprinkler head box is located. This deficient practice was verified by the Maintenance Director (JS).	K 056		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and observations, it was determined that the facility has failed to ensure that cleaning and inspection of the kitchen hood system protecting the cooking appliances has been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect all, staff and visitors. Findings Include:	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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

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K 069	Continued From page 4 On facility tour between 10:30 AM to 1:30 PM on 07/23/2013, during the review of all available documentation for the kitchen hood ventilation system inspection reports the facility could not provide any documentation showing that the kitchen hood/ventilation system that is integral to the hood suppression system has been completely cleaned and professionally inspected within the last six month. At the time of the inspection the last inspection of the kitchen hood ventilation system was conducted on 09/28/2012 which was greater than 6 month prior to this inspection. This deficient practice was verified by the Maintenance Director (JS).	K 069		

Auburn
HOMES & SERVICES

SERVING SENIORS
IN THE SPIRIT OF CHRIST'S LOVE

501 North Oak Street • Chaska, MN 55318 • 952.448.9303 • www.auburnhomes.org

DATE: August 23, 2013

SUBJECT: Plan of Correction for the Life Safety Code Survey completed at Auburn Manor in Chaska, 501 North Oak Street, Chaska, Minnesota on July 23, 2013 by the Minnesota State Fire Marshal's Office.

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).

K 056 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor has an automatic sprinkler system which is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. It is the intention of the facility that the system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

On 7/23/2013, during the Life Safety Code Survey, the following concern was noted:

The spare sprinkler head box was not equipped with at least 2 of every type of sprinkler heads that are being used in the facility.

Plan of Correction:

1. The missing spare sprinkler heads have been replaced. The chief engineer for the facility will monitor the inventory of spare sprinkler heads and ensure that there are at least 2 heads for each type of sprinkler head in the building at all times. This monitoring will be coordinated to correspond with the facility's monthly fire drill schedule. The quality assurance committee will monitor fire and safety hazard inspection results, for compliance, and make recommendations, when appropriate, to facility administration on an as needed and quarterly basis.

Timeline for Correction: Date of completion not to exceed September 3, 2013.

K 069 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor intends to protect its cooking facilities in accordance with 9.2.3 19.3.2.6, NFPA 96 which addresses the cleaning and inspection of the kitchen hood system protecting the cooking appliances. NFPA 96 8-3.1 table 8-3.1 states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semi-annually by a properly trained, qualified, and certified company or person.

On 7/23/2013, during the Life Safety Code Survey, the following concern was noted:

During the review of all documentation for the kitchen hood ventilation system inspection reports, it was determined that more than 6 months had elapsed since the last time that the kitchen hood/ventilation system had been completely cleaned and professionally inspected.

Plan of Correction:

1. The qualified technician arrived during the survey to complete the cleaning and inspection of the kitchen hood/ventilation system. This process was completed the day of the survey.
2. The chief engineer for the facility will monitor the kitchen hood/ventilation system cleaning and inspection schedule to ensure semi-annual cleaning and inspection of the named equipment. In the event that scheduling and/or performance of required service becomes problematic, the chief engineer will notify the administrator. Compliance with the semi-annual cleaning and inspection requirement will be monitored as part of the facility's safety committee functions. This monitoring will be coordinated to correspond with the facility's monthly fire drill schedule. The quality assurance committee will monitor fire and safety hazard inspection results, for compliance, and make recommendations, when appropriate, to facility administration on an as needed and quarterly basis.

Timeline for Correction: Date of completion not to exceed September 3, 2013.

Respectfully Submitted,

Rick Krant
Administrator

F560421

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

PRINTED: 08/12/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/23/2013

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
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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, 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 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	(See Attached) PICoh 8-26-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/23/13

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.

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 _____	07/23/2013

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
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The 2006 addition to Auburn Manor is a one (1) story building with no basement. The construction type is determined to be Type II(111) The building is separated from the rest of the facility by 2 hour fire rated construction , with a 1 & 1/2 hour rated fire door. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 61 beds, and the addition has no sleeping rooms.	K 000		

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 _____	07/23/2013

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
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on	K 056		

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 _____	07/23/2013

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K 056	Continued From page 3 07/23/2013, observations reveled that the spare sprinkler head box was not equipped with at least 2 of every type of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the same type as the ones located in the lower level Mechanical room where the main sprinkler riser and spare sprinkler head box is located. This deficient practice was verified by the Maintenance Director (JS).	K 056		

Auburn
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DATE: August 23, 2013

SUBJECT: Plan of Correction for the Life Safety Code Survey completed at Auburn Manor in Chaska, 501 North Oak Street, Chaska, Minnesota on July 23, 2013 by the Minnesota State Fire Marshal's Office.

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).

K 056 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Manor has an automatic sprinkler system which is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. It is the intention of the facility that the system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

On 7/23/2013, during the Life Safety Code Survey, the following concern was noted:

The spare sprinkler head box was not equipped with at least 2 of every type of sprinkler heads that are being used in the facility.

Plan of Correction:

1. The missing spare sprinkler heads have been replaced. The chief engineer for the facility will monitor the inventory of spare sprinkler heads and ensure that there are at least 2 heads for each type of sprinkler head in the building at all times. This monitoring will be coordinated to correspond with the facility's monthly fire drill schedule. The quality assurance committee will monitor fire and safety hazard inspection results, for compliance, and make recommendations, when appropriate, to facility administration on an as needed and quarterly basis.

Timeline for Correction: Date of completion not to exceed September 3, 2013.

Respectfully Submitted,

Rick Krant
Administrator