Electronically Delivered

October 16, 2025

Licensee
Auburn Meadows LLC
591 Cherry Drive
Waconia, MN 55387

RE: Project Number(s) SL28788016

Dear Licensee:

On September 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 26, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

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August 18, 2025

Licensee
Auburn Meadows LLC
591 Cherry Drive
Waconia, MN 55387

RE: Project Number(s) SL28788016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

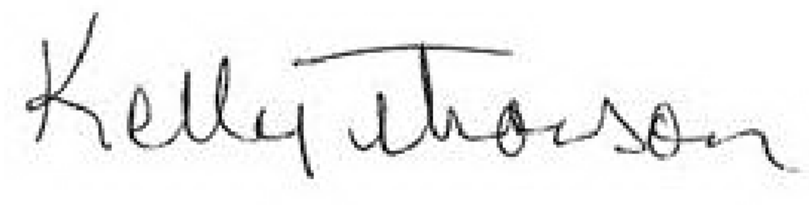
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28788	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28788016 On June 23, 2025, through June 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 60 residents; 60 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on June 24, 2025, issued for SL28788016, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 660	Continued From page 1	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening for one of two employees (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 660		

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0 660	Continued From page 2 The facility TB risk assessment was completed July 8, 2024, and indicated the facility was at a low risk for TB transmission. ULP-F was hired August 7, 2024, and provided direct care services to residents. ULP-F's record lacked a TB history and symptom screen. On June 25, 2025, at 12:35 p.m., clinical nurse supervisor (CNS)-A stated the TB history and symptom screening should have been completed and is not sure why it was missed. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Employee Tuberculosis Prevention and Control Program policy reviewed/dated February 2023, indicated Clinical Director, RN is responsible for establishing and maintaining the TB prevention and control program. Responsibilities include educating new employees regarding TB transmission, signs and symptoms of active TB disease, and the facility's infection control plan, screening all employees, contractors, students, and regularly scheduled	0 660		

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0 660	Continued From page 3 volunteers for TB, and maintaining all reports of TB screening in employee files. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On June 25, 2025, from 11:00 a.m. to 3:30 p.m., the surveyor toured the facility with director of facility services (DFS)-G. During the tour, the surveyor observed: CONTROLLED EGRESS Controlled egress doors throughout the facility,	0 775		

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0 775	Continued From page 4 surveyor asked DFS-G the location of the switch or device that unlocks all doors. A signal or switch to unlock the egress doors was not found or was not known by staff. MN Fire code states, egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. FIRE DOORS: Fire door on the 3rd floor laundry room was missing an automatic closing mechanism. Swinging fire doors shall close from the full-open position and latch automatically. During a facility tour on June 25, 2025, at 2:30 p.m., DFS-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 5 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 6 On June 25, 2025, from 11:00 a.m. to 3:30 p.m., the surveyor toured the facility with director of facility services (DFS)-G. surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for staff, residents and visitor accessibility. Facility was keeping the binder in a supply room which was locked after hours. DFS-G stated that they will keep the door unlocked in the future. June 25, 2025, from 11:00 a.m. to 3:30 p.m., with DFS-G; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety and Evacuation Plan", dated December 2021, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was not the only documentation facility was using for evacuation. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was a section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency but located in another book near the front entrance. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website	0 810		

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0 810	Continued From page 7 for standard resident evacuation procedures. The FSEP does not include instructions on how to use/access or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On June 25, 2025, at 2:30 p.m., DFS-G stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. DFS-G stated staff does web-based training at the time of hire and before a fire drill. No other training documentation was provided. On June 25, 2025, at 2:30 p.m., DFS-G stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290		

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01290	Continued From page 8 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and completed for the current health facility identification (HFID) number for two of two employees (licensed practical nurse (LPN)-C and unlicensed personnel (ULP-D) on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). This resulted in an immediate correction order issued on June 24, 2025. The findings include: On June 23, 2025, at 2:00 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered two of the facility's employees were not listed as having background studies	01290		

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01290	Continued From page 9 submitted with the licensee's HFID 28788. LPN-C was hired on January 2, 2018, to provide direct care and services to the licensee's residents. LPN-C provided direct care services without direct supervision on June 10, 11, 12, and 23, 2025. A current background study had not been completed for LPN-C. ULP-D was hired on November 25, 2024, to provide direct care and services to the licensee's residents. ULP-D provided direct care services without direct supervision on April 27, 2025. A current background study had not been completed for ULP-D. On June 24, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated they do not have documentation of current background studies for LPN-C and ULP-D. On June 24, 2025, at 12:10 p.m., CNS-A stated both LPN-C and ULP-D have worked without direct supervision. The licensee's Background Studies policy dated July 1, 2021, indicated background studies are performed, managed, and stored by the human resources department under the direction of the Department of Health and Human Services. Individuals will not have unsupervised direct resident contact until verification has been received from the background study that provides approval to work with vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		

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01440	Continued From page 10	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01440		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: ULP-E began employment on July 10, 2023. ULP-F began employment on August 7, 2023. ULP-E and ULP-F's employee records lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On June 25, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated there has been a lot of turnover in the human resources and the nursing departments, they are transitioning from paper to electronic records and have recently changed the electronic system they are using. They are sure the missing requirements have been completed but they cannot find the documentation. The licensee's undated Supervision of Staff policy indicated staff providing delegated tasks will be supervised and monitored withing the first 30 days after the individual begins working for the home care provider. Documentation of direct observation is maintained in the employee's personnel file. No further information was provided.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28788	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 13 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for two of two employees (unlicensed personnel (ULP-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 14 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The findings include: ULP-E began employment on July 10, 2023. ULP-F began employment on August 7, 2023. ULP-E and ULP-F's employee records lacked the following required orientation content: -handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services On June 25, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated there has been a lot of turnover in the human resources and the nursing departments, they are transitioning from paper to electronic records and have recently changed the electronic system they are using. They are sure the missing requirements have been completed but they cannot find the documentation. The licensee's Orientation- All Staff policy dated August 1, 2021, indicated newly hired staff will receive orientation and training topics required for assisted living organizations to include the complaint process, handling resident complaints, the organization's system for receiving and	01470		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

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01470	Continued From page 15 responding to complaints, where and how to report complaints, contact information for the Office of Health Facility Complaints, contact information for the Office of the Ombudsman for long-term care, and contact information for the Office of the Ombudsman for Mental Health and Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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AUBURN MEADOWS LLC	591 CHERRY DRIVE WACONIA, MN 55387

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01500	Continued From page 16 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F).	01500		

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01500	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-F began employment on August 7, 2023. ULP-F's employee record lacked the following required annual training: -reporting maltreatment of vulnerable adults or minors -assisted living bill of rights -infection control techniques -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -review of provider's policies and procedures -principles of person-centered planning and service delivery On June 25, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated there has been a lot of turnover in the human resources and the nursing departments, they are transitioning from paper to electronic records and have recently changed the electronic system they are using. They are sure the missing requirements have been completed but they cannot find the documentation. The licensee's Annual Training policy dated August 1, 2021, indicated all assisted living	01500		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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01500	Continued From page 18 employees will complete annual education on the following topics: -reporting of maltreatment of vulnerable adults under section 626.557 -assisted living bill of rights -staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights -infection control techniques used in the home and implementation of infection control standards -effective approaches for problem solving when working challenging behaviors -effective approaches for communication with residents with dementia, Alzheimer's disease, or related disorders -review of policies and procedures relating to the provision of assisted living services and how to implement them -how person-centered planning and service delivery applies to direct support services provided by staff. -emergency and disaster training No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours	01540		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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01540	Continued From page 19 of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of two unlicensed personnel (ULP)-F) received the required eight hours of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: ULP-F began employment on August 7, 2023. ULP-F's employee record lacked evidence of having completed eight hours of dementia	01540		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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01540	Continued From page 20 training within the required time frame. On June 25, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated there has been a lot of turnover in the human resources and the nursing departments, they are transitioning from paper to electronic records and have recently changed the electronic system they are using. They are sure the missing requirements have been completed but they cannot find the documentation. The licensee's Dementia Care Training policy dated August 1, 2021, indicated direct care staff and supervisors of direct care staff receive at least eight hours of initial dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for one of one resident (R1), failed to keep a medication in its original container bearing the original prescription label for two of two residents	01890		

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	28788	A. BUILDING: _____ B. WING _____	06/26/2025

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01890	Continued From page 21 (R1 and R7), and failed to monitor for expired medications for three of three residents (R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 25, 2025, at 8:50 a.m., the surveyor observed medication carts. In the first medication cart observed a bottle of nitro stat 0.4mg for R5 expired on October 23, 2024, Salonpas pain patches for R6 expired in March of 2025, and refresh eye drops for R7 expired in September of 2023 and did not have a pharmacy prescription label attached. Furthermore, a bottle of dorzolamide eye drops for R7 did not have a pharmacy prescription label attached. In the second medication cart observed Lantus and Humalog insulin pens for R5 were found without opened or expiration dates and neither pen had a pharmacy prescription label attached. On June 25, 2025, at 9:10 a.m., unlicensed personnel (ULP)-H stated ULP's should be looking for expired medications and the eye drops should be in boxes with the pharmacy prescription label on them. On June 25, 2025, at 9:25 a.m., ULP-I stated insulin pens should be marked with the date they are opened and should have prescription labels	01890		

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01890	Continued From page 22 on them to be able to compare the information to the medication administration record (MAR). The manufacturer's instruction for storing opened pens of Lantus indicated, store the Lantus SoloStar injection pen at room temperature (do not refrigerate) and use within 28 days. The manufacturer's instructions for storing opened (in use) Humalog pens indicated, store the cartridge or injection pen (without a needle attached) at room temperature and use within 28 days. On June 25, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-A stated the pharmacist comes out quarterly to audit the medication carts, nursing checks on a regular basis, and the ULP's should be checking for expired medications as well. CNS-A further stated all medication should have pharmacy prescription labels attached, and all insulin pens and eye drops should be labeled with the open date. The licensee's Medication Management: Attainment/Storage/Disposition/Reconciliation policy reviewed/revised June 2022, indicated medication that is managed by the home care agency will be appropriately received, stored, accounted for and disposed of. Oversight of medication management occurs at a frequency that ensures the safe and efficient management of the client's medication. Medications are maintained in their original pharmacy supplied packaging. Medications that are purchased privately and are provided by the client or client's representative are kept in the original container with the manufacturer's labeling intact. The client's full name is written on the container. Any medication that does not contain appropriate	01890		

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01890	Continued From page 23 labeling will be disposed of and a new supply will be obtained. A periodic review of the storage of medications within the facility will include observe for expiration dates and observe for date opened stickers and the date of expiration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Auburn Meadows LLC
591 Cherry Drive
Waconia, MN 55387
Carver County
Parcel:

Phone:

License Info

License: HFID 8788

Risk:
License:
Expires on:
CFPM: BERNARD MATTHEW SCHNEIDER
CFPM #: FM37098; Exp: 02/26/2028

Inspection Info

Report Number: F8087251047
Inspection Type: Full - Single
Date: 6/24/2025 Time: 9:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER BERNARD MATTHEW SCHNEIDER.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO ASSIGNED NURSE SURVEYOR.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8087251047 from 6/24/2025

John Boettcher

BERNARD MATTHEW SCHNEIDER
KITCHEN MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Auburn Meadows LLC
Waconia
County/Group: Carver County

Inspection Info

Report Number: F8087251047
Inspection Type: Full
Date: 6/24/2025
Time: 9:30:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Walk-in Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Walk-in Freezer at -19 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 32 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** DELI MEAT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Under Counter Freezer at -8 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Under Counter Freezer at 27 Degrees F.
Comment: CAFE
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Under Counter Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Auburn Meadows LLC
Waconia
County/Group: Carver County

Inspection Info

Report Number: F8087251047
Inspection Type: Full
Date: 6/24/2025
Time: 9:30:00 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No