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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HZYK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00053

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245583**

2. STATE VENDOR OR MEDICAID NO. (L2) **211027000**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN HOME IN WACONIA**
(L4) **594 CHERRY DRIVE**
(L5) **WACONIA, MN** (L6) **55387**

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 **06/14/2017** (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 **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 06/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/28/2017 (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 **11/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245583

June 28, 2017

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

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 May 30, 2017 the above facility is certified for or recommended for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2017

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

RE: Project Number S5583025

Dear Mr. Krant:

On May 4, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 20, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 1, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 20, 2017, effective May 30, 2017 and therefore remedies outlined in our letter to you dated May 4, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 28, 2017

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

Re: Reinspection Results - Project Number S5583025

Dear Mr. Krant:

On June 14, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 14, 2017, with orders received by you on May 4, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HZYK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00053

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2. STATE VENDOR OR MEDICAID NO. (L2) **211027000**

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(L3) **AUBURN HOME IN WACONIA**
(L4) **594 CHERRY DRIVE**
(L5) **WACONIA, MN** (L6) **55387**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/20/2017** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 05/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/26/2017 (L20)

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

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____ 2. Facility is not Eligible
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11/01/1991
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 4, 2017

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

RE: Project Number S5583025

Dear Mr. Krant:

On April 20, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 30, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	**594 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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		5/30/17

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

Electronically Signed | 05/11/2017

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
	245583	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 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) COMPLETION DATE
F 156	Continued From page 1	F 156		

personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/20/2017

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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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F 156	Continued From page 4	F 156		

regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate notices for 1 of 3 residents (R9) who remained in the facility following a Medicare covered stay.	F 156	It is the policy, and intention, of Auburn Home in Waconia to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to	

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F 156	Continued From page 6 Findings include: R9' received a Notice of Medicare Non-Coverage 1/2/17, for a coverage end date of 1/4/17. R9 remained in the the facility, but did not receive a determination of continued stay. During an interview on 4/19/17, at 3:22 p.m., social service representative (SS)-A stated R9's Medicare coverage was terminated because the facility needed to"save the days." She stated R9 remained in the facility for possible end of life. SS-A stated R9's therapy was re-instated on 1/12/17 and continued until 1/27/17 when her benefits exhausted. SS-A stated the facility provided the notice of non coverage, but had not provided the determination of continued stay and stated she was unaware of the form. During interview on 4/19/17, at 4:05 p.m., the administrator stated he was no aware of what notices were to be given, but he expected the facility to be giving the correct notices. A facility policy was requested, but not received.	F 156	the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility□s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. The scenario reflected in the example is a rare occurrence at Auburn Home. This contributed to SS-A's unfamiliarity with the form resulting in R9 not receiving it. During the survey, SS-A contacted another of our skilled care facilities and reoriented herself on the determination of continued stay form referenced in the example. That form was immediately put into practice. Facility Wide Response Affecting All Residents: 1. The facility□'s interdisciplinary team (IDT) and social service staff have been educated on the required determination of continued stay documentation requirements for residents who have been accessing their skilled nursing Medicare Benefits and are no longer coverable. 3. Ongoing: Quarterly random sample	

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F 156	Continued From page 7	F 156	audits of residents who had accessed their Medicare Skilled Nursing Care Benefit will be conducted utilizing the CMS QIS Demand Billing auditing tool to ensure compliance with the requirements at F 156. 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 interventions made, during the quarterly quality assurance meetings.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess 1 of 2 residents (R36) for safe use of the standing lift for transfers. Findings include:	F 274	It is the policy and practice of Auburn Home in Waconia to comprehensively assess residents when a significant change in a resident's physical or mental condition has been identified. These assessments include an Interdisciplinary Team (IDT) approach in the analysis of all	5/30/17

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 274	Continued From page 8 R36's significant change Minimum Data Set (MDS) dated 11/20/16, indicated he was severely cognitively impaired and required extensive assist of two staff to transfer. The MDS indicated R36 had balance that was unsteady and was unable to stabilize without assistance. A Care Area Assessment (CAA) for falls dated 11/10/16, indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The CAA for functional status dated 11/10/16, indicated R36 had weakness, decreased endurance and hemiparesis (weakness on one side of the body) that could effect transfers. R36's care plan dated 6/21/12, indicated two staff assist to transfer using a sit to stand lift. The care plan did not address the use of the lift to transport R36 from the bed to the bathroom. During observation on 4/19/17, at 7:50 a.m., R36 was transferred from the bed to the bathroom in a standing lift. Nursing assistant (NA)-B operated the lift and the director of nursing (DON) was next to R36. R36 had a sling around his back, his knees were bent and he was leaning back on the sling instead of standing upright. R36 was pushed around the end of the bed, into the entrance alcove, and into the bathroom during the transport of approximately 20 feet. The lift went over carpeted floor, over a plastic threshold, and onto the bathroom flooring. R36 was lowered onto the toilet then transferred from the toilet to a wheelchair positioned in the bathroom. The DON stated at the time of the transfer it was usual to use the standing lift to transport R36 from the bed to the bathroom with assist of 2 staff. NA-B was interviewed on 4/19/17, at 9:10 a.m.,	F 274	assessment collected data. As noted in the surveyor's example, R36 significant change MDS dated 11/20/16, indicated he required extensive assistance of two to transfer. Additionally, it referenced R36 as unsteady and unable to stabilize without assistance. A Care Area Assessment for falls dated 11/10/16 indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The surveyor notes in her example that the lift went over carpeted floor, over a plastic threshold, and onto bathroom flooring. Given the number of different flooring transitions and the resident's aforementioned impaired balance during transitions, it is the facility's position that the standing lift was the appropriate intervention and consistent with standards of practice. The carpeted floor, over a plastic threshold, and onto the bathroom flooring transitions that the surveyor referenced do not exceeded 1/8 inch. The surveyor stated that the resident was transported approximately 20 feet. The actual distance was 13 feet per the facility's actually measurement of the distance. The surveyor stated that a representative for the standing lift was interviewed regarding the recommended use of the standing lift. That representative allegedly stated that the manufacturer's recommendations indicated that the lifts were designed for transferring only, not for transporting for long distances. No	

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 274	Continued From page 9 and stated the standard way to transfer R36 was using the standing lift "since a long time ago," and the lift was used to transport to R36 to the bathroom. She stated this was standard operating procedure in the facilty. During an interview on 4/19/17, at 10:30 a.m., registered nurse (RN-A) stated she was aware of the standing lift being used to transport R36 to the bathroom and knew of no problems with standing lift transfers and stated there were no incidents related to use of the lift in the past year. RN-A stated was not aware of an assessment for approval of the standing lift for R36. The representative for the standing lift provider was interviewed on 4/19/17, at 1:00 p.m. The representative stated the manufacturer's recommendations indicated the lifts were designed for transferring only, not for transporting for long distances. He stated the distance that was safe would be determined by the individual resident's assessment. He stated that transporting with obstructions such as turns, furniture, and over multiple flooring surfaces would also be a factor in determining risk. He stated the base legs should remain in the wide position when the resident is up in the lift which may be difficult through a doorway. Physical therapist (PT)-A was interviewed on 4/19/17, at 2:00 p.m., and stated she had seen R36 recently to increase leg strength. She stated she would do an initial assessment for residents using a standing lift, and would reassess if asked. PT-A stated she could not recall an assessment for R36 to use the standing lift but stated he had used it for a long time and no issues had been mentioned in team meetings.	F 274	definition of what a 'long distance' was given. Upon review of the manufacturer's recommendations for the Volaro Stand-PA/PAS on page 6 of the Operator's Manual, transferring from a chair to a commode, transferring from chair to bed, and transferring from bed to chair are all implicated as acceptable usage of the standing lift. These examples of appropriate use of the lift are consistent with what the lift was being used for on 4/19/17. Actual verbiage on page 6 of the Operator's Manual states, "Now that the person being transferred is clear of chair, unlock the brakes and roll him to the commode or bathroom." Facility staff were following the manufacturer's Operating Manual. The resident had a comprehensive assessment on 11/7/16 compliant with the RAI process. Quarterly assessments were completed on 1/30/17 and again on 4/24/17. During these assessments, data was collected pertaining to all ADL functions including transferring and mobility. Regarding R36 transfer status, the resident has been assessed by physical therapy for appropriate lifting equipment to be used in his plan of care. The appropriate documentation supporting the intervention of using the standing lift was documented in the resident's care plan. Facility Wide Response Affecting All Residents:	

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F 274	Continued From page 10 During interview on 4/19/17, at 3:20 p.m., the DON stated the facility had not defined the distance that the standing lift could be used for transport. At 4:30 p.m., the DON stated she was not able to locate an assessment for R36's ability to use the standing lift. The manufacturer's recommendations for the standing lift "Volaro PA600/PA600S" dated 5/25/2011, directed that "Volaro lifts are designed for transferring only, not for transporting over long distances. Because the Volaro sit to stand lift was designed as an assistive device, it requires more advanced motor skills than a traditional full body lift. It is important to first determine the appropriateness of the piece of equipment for any patient." The facility policy titled Mechanical Stand and Lift Policy dated February 2017, indicated "The mechanical stand and lift should only be used for residents assessed by a licensed health professional to be appropriate for use and identified in the resident record."	F 274	1. The facility□'s interdisciplinary team (IDT) and licensed nursing staff have been re-educated on the required resident assessnents prior to the initiation or discontinuation of mechanical stands and lifts. 2. The rehabilitation services department will conduct the mechanical stand and lift resident assessments as part of the RAI Comprehensive or Significant Change Assessments process. 3. Ongoing: Residents utilizing mechanical stands and/or lifting equipment will be reviewed quarterly by the IDT at the quarterly care assessment, to ensure that the identified assessments have been completed. The outcome data obtained from these reviews 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 interventions made, during the quarterly quality assurance meetings.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of	F 282		5/30/17

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 282	Continued From page 11 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the plan of care for repositioning and personal hygiene (check and change program) for 1 of 2 residents (R45) reviewed for positioning and activities of daily living (ADL's.) Findings include: R45's significant change Minimum Data Set (MDS) dated 3/27/17, indicated she was severely cognitively impaired, dependent on staff for all ADL's and was always incontinent of bowel and bladder. An Auburn Home Waconia Bladder Assessment dated 3/24/17, indicated R45 was unable to recognize and respond to signals to toilet and was on a scheduled toileting program. R45's care plan dated 4/7/17, directed facility staff to assist with toileting. The care plan indicated R45 was on a Dignity Care Program (routine checking and changing for incontinence management.) The care plan did not identify a frequency for the check and change program. Continuous observation on 4/19/17, from 7:00 a.m. to 10:32 a.m., identified the following: At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed. At 7:25 a.m., R45 remained seated in the Broda chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and	F 282	The services provided or arranged by Auburn Home in Waconia,as outlined by the comprehensive care plan, is provided by qualified persons in accordance with each resident's written plan of care. In the example cited by the surveyor, R45 was involved in a planned activity on the morning of 4/19/17. The extended period of her repositioning and incontinence check was the outcome of miscommunication between facility staff and the resident participating in meaningful activities during the observed time period referenced by the surveyor. The resident's care plan was reviewed to ensure every two hour repositioning and incontinence checks are included. In addition, the frequency of positioning changes and incontinence checks has been emphasized on the nursing assistant care worksheets. Facility Wide Response Affecting All Residents: 1. The facility□'s Resident Repositioning and Incontinence Monitoring Policy has been revised to include verbiage addressing the facility's standard every 2 hour repositioning and incontinence monitoring requirement for residents unable to reposition themselves and for incontinent residents. The policy also addresses that every resident will have an	

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F 282	Continued From page 12 walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required staff assistance with all cares which included routine repositioning of every 2 hours. At 10:27 a.m., RN-C approached R45 and escorted her to the bathroom. RN-B removed R45's moderately urine soiled incontinent brief and lowered her to the toilet where she voided a large amount of urine. RN-A then left the room, and nursing assistant (NA)-A entered R45's bathroom, at that time RN-C and NA-A assisted R45 off the toilet and back into her Broda chair. During interview on 4/19/17, at 10:27 a.m., RN-C stated R45 was totally dependent on facility staff	F 282	individualized repositioning and bathroom plan of care based upon the resident's comprehensive assessment. 2. Staff education consisted of a 'Read and Sign' education module which addressed resident repositioning and incontinence monitoring. The module included the following: "Please remember to always review the NAR worksheet and binder prior to your work shift to be sure that you are aware of any changes in your residents prior to beginning any cares. The NAR binder and treatment book will also be flagged with a red paper with those residents requiring turning and repositioning or off loading per exception of the standard of 2 hours. All residents plan of care information pertinent to providing care is located on the NAR worksheet. Staff are required to follow the NAR worksheet or ask the nurse for direction." 3. Ongoing: Quarterly random sample audits of residents who are unable to reposition themselves, and/or are incontinent, will consist of observations of the time between repositioning and incontinence monitoring to ensure that it is not in excess of every 2 hours or as the individualized plan of care indicates for the resident. 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 interventions made, during the quarterly quality assurance	

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F 282	Continued From page 13 for all ADL's and was unable to let the facility staff know of her needs, including toileting. RN-C stated R45 required every 2 hour checking and changing to manage urinary incontinence. During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs. RN-B stated R45 was on a routine check and changing program to manage urinary incontinence. RN-B stated R45 at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of when R45 had gotten up for the day and stated R45 should have been repositioned at least every 2 hours. During an interview on 4/19/17, at 10:45 a.m., NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated R45 was on a every 2 hour routine check and change program for incontinence and repositioning. During an interview on 4/19/17, at 12:59 p.m., RN-A confirmed R45 was incontinent of both bowel and bladder and was totally dependent on facility staff for toileting and hygiene. RN-A stated R45 was on a Dignity Care program which included a routine checking and changing program for incontinence management. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours and at that time she would expect facility staff to check R45's incontinence brief and change as needed.	F 282	meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/20/2017

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 282	Continued From page 14 During an interview on 4/19/17, at 1:35 p.m., TMA-A stated R45 was unable to verbalized her needs and required assistance with every 2 hour checking and changing with repositioning. During an interview on 4/19/17, at 2:15 p.m., the director of nursing (DON) stated bowel and bladder assessments were completed quarterly for residents and based on the assessment, interventions were put into place to manage incontinence. She stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated if Dignity Care was in place for a resident, such as R45, she would expect at the time of repositioning, R45 to be checked and changed for incontinence. She further stated the facility did not have a specific policy and procedure for following a residents care plan and indicated it was an expectation all staff were aware of.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a timely check and change program for urinary incontinence management for 1 of 2 residents (R45) reviewed for activities of daily living (ADL's.) Findings include:	F 312	It is the policy and practice of Auburn Home in Waconia to provide residents who are unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. comprehensively assess residents when a significant change in a resident's physical	5/30/17

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 312	Continued From page 15 R45's significant change Minimum Data Set (MDS) dated 3/27/17, indicated she was severely cognitively impaired, dependent on staff for all ADL's and was always incontinent of bowel and bladder. Review of R45's Care Area Assessment (CAA) dated 3/27/17, indicated she was totally dependent on facility staff for ADL's, including toileting and personal hygiene and indicated she was always incontinent of bowel and bladder and no longer used the toilet. An Auburn Home Waconia Bladder Assessment dated 3/24/17, indicated R45 was unable to recognize and respond to signals to toilet and was on a scheduled toileting program. R45's care plan dated 4/7/17, directed facility staff to assist with toileting. The care plan indicated R45 was on a Dignity Care Program (routine checking and changing for incontinence management.) Continuous observation on 4/19/17, from 7:00 a.m. to 10:32 a.m., identified the following: At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed. At 7:25 a.m., R45 remained seated in the Broda chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in	F 312	or mental condition has been identified. These assessments include an Interdisciplinary Team (IDT) approach in the analysis of all assessment collected data. In the example cited by the surveyor, R45 was involved in a planned activity on the morning of 4/19/17. The extended period of her repositioning and incontinence check was the outcome of miscommunication between facility staff and the resident participating in meaningful activities during the observed time period referenced by the surveyor. The resident's care plan was reviewed to ensure every two hour repositioning and incontinence checks are included. In addition, the frequency of positioning changes and incontinence checks has been emphasized on the nursing assistant resident care cards. Facility Wide Response Affecting All Residents: 1. The facility□'s Resident Repositioning and Incontinence Monitoring Policy has been revised to include verbiage addressing the facility's standard every 2 hour repositioning and incontinence monitoring requirement for residents unable to reposition themselves and for incontinent residents. The policy also addresses that every resident will have an individualized repositioning and bathroom plan of care based upon the resident's comprehensive assessment.	

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F 312	Continued From page 16 the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required staff assistance with all cares which included routine repositioning of every 2 hours. At 10:27 a.m., RN-C approached R45 and escorted her to the bathroom. RN-B removed R45's moderately urine soiled incontinent brief and lowered her to the toilet where she voided a large amount of urine. RN-A then left the room, and nursing assistant (NA)-A entered R45's bathroom, at that time RN-C and NA-A assisted R45 off the toilet and back into her Broda chair. During interview on 4/19/17, at 10:27 a.m., RN-C stated R45 was totally dependent on facility staff for all ADL's and was unable to let the facility staff know of her needs, including toileting. RN-C stated R45 required every 2 hour checking and changing to manage urinary incontinence. During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs.	F 312	2. Staff education consisted of a 'Read and Sign' education module which addressed resident repositioning and incontinence monitoring. The module included the following: "Please remember to always review the NAR worksheet and binder prior to your work shift to be sure that you are aware of any changes in your residents prior to beginning any cares. The NAR binder and treatment book will also be flagged with a red paper with those residents requiring turning and repositioning or off loading per exception of the standard of 2 hours. All residents plan of care information pertinent to providing care is located on the NAR worksheet. Staff are required to follow the NAR worksheet or ask the nurse for direction." 3. Ongoing: Quarterly random sample audits of residents who are unable to reposition themselves, and/or are incontinent, will consist of observations of the time between repositioning and incontinence monitoring to ensure that it is not in excess of every 2 hours or as the individualized plan of care indicates for the resident. 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 interventions made, during the quarterly quality assurance meetings.	

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F 312	Continued From page 17	F 312		

RN-B stated R45 was on a routine check and changing program to manage urinary incontinence. RN-B stated R45 at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of when R45 had gotten up for the day and stated R45 should have been repositioned at least every 2 hours.

During an interview on 4/19/17, at 10:45 a.m., NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated R45 was on a every 2 hour routine check and change program for incontinence and repositioning.

During an interview on 4/19/17, at 12:59 p.m., RN-A confirmed R45 was incontinent of both bowel and bladder and was totally dependent on facility staff for toileting and hygiene. RN-A stated R45 was on a Dignity Care program which included a routine checking and changing program for incontinence management. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours and at that time she would expect facility staff to check R45's incontinence brief and change as needed.

During an interview on 4/19/17, at 1:35 p.m., TMA-A stated she had assisted R45 to get up for the day at approximately 6:45 a.m. TMA-A stated R45 was unable to verbalized her needs and required assistance with every 2 hour checking and changing with repositioning.

During an interview on 4/19/17, at 2:15 p.m., the

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 312	Continued From page 18 director of nursing (DON) stated bowel and bladder assessments were completed quarterly for residents and based on the assessment, interventions were put into place to manage incontinence. She stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated if Dignity Care was in place for a resident, such as R45, she would expect at the time of repositioning, R45 to be checked and changed for incontinence. The DON stated the facility did not have a policy or procedure which addressed Dignity Care or checking and changing program for incontinence.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure timely	F 314	Based on the comprehensive assessment of a resident, Auburn Home	5/30/17

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F 314	Continued From page 19 repositioning for 1 of 1 residents (R45) reviewed for positioning and identified at risk for skin breakdown. Findings include: R45's significant change of status Minimum Data Set (MDS) dated 3/27/17, indicated she had severe cognitive impairment related to dementia. The MDS indicated she was totally dependent on facility staff for all activities of daily living (ADL's) and identified a risk for pressure ulcer development. Review of a Braden Scale for Predicting Pressure Ulcer Risk, dated 3/24/17, indicated R45 was at high risk for skin breakdown based on moisture, decreased mobility, activity, nutrition, friction and shear. Review of a Tissue Tolerance Assessment (a tool used to assess risk for skin breakdown,) dated 3/24/17, identified R45 was required interventions to maintain healthy skin which included; turning and repositioning every 2 hours and a cushion in the Broda chair. Review of R45's Care Area Assessment (CAA) dated 3/27/17, indicated she was unable to verbally communicate her needs, was totally dependent on facility staff for ADL's and directed staff to anticipate her needs. The CAA revealed R45 was at high risk for skin breakdown, had a history of moisture associated skin damage (MASD) and had listed various interventions that were in place to prevent skin breakdown which included; facility staff assist to reposition every two hours, pressure relieving surfaces and added protein to her diet. R45's care plan dated 4/7/17, identified a risk for skin breakdown related to severe dementia,	F 314	in Waconia's standard of practice ensures that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless the individual□'s clinical condition demonstrates that they were unavoidable. In the example cited by the surveyor, R45 was involved in a planned activity on the morning of 4/19/17. The extended period of her repositioning and incontinence check was the outcome of miscommunication between facility staff and the resident participating in meaningful activities during the observed time period referenced by the surveyor. The resident's care plan was reviewed to ensure every two hour repositioning and incontinence checks are included. In addition, the frequency of positioning changes and incontinence checks has been emphasized on the nursing assistant resident care cards. Facility Wide Response Affecting All Residents: 1. The facility□'s Resident Repositioning and Incontinence Monitoring Policy has been revised to include verbiage addressing the facility's standard every 2 hour repositioning and incontinence monitoring requirement for residents unable to reposition themselves and for incontinent residents. The policy also addresses that every resident will have an	

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F 314	Continued From page 20 mobility, cognitive deficits and fragile skin. The care plan directed facility staff to turn and reposition every 2 hours from the cushioned Broda wheelchair to recliner to bed. At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed. At 7:25 a.m., R45 remained seated in the Broda chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required	F 314	individualized repositioning and bathroom plan of care based upon the resident's comprehensive assessment. 2. Staff education consisted of a 'Read and Sign' education module which addressed resident repositioning and incontinence monitoring. The module included the following: "Please remember to always review the NAR worksheet and binder prior to your work shift to be sure that you are aware of any changes in your residents prior to beginning any cares. The NAR binder and treatment book will also be flagged with a red paper with those residents requiring turning and repositioning or off loading per exception of the standard of 2 hours. All residents plan of care information pertinent to providing care is located on the NAR worksheet. Staff are required to follow the NAR worksheet or ask the nurse for direction." 3. All nursing assistant staff will be assigned a skin integrity and pressure ulcer prevention learning module on the facility's on-line continuing education learning program. 3. Ongoing: Quarterly random sample audits of residents who are unable to reposition themselves, and/or are incontinent, will consist of observations of the time between repositioning and incontinence monitoring to ensure that it is not in excess of every 2 hours or as the individualized plan of care indicates for the resident. These audits will be	

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	245583	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 314	Continued From page 21 staff assistance with all cares which included routine repositioning of every 2 hours. At 10:27 a.m., RN-C approached R45 and wheeled her into the bathroom. RN-B brought in a sit to stand mechanical lift and RN-B and RN-C assisted R45 out of the Broda chair. Upon removal of R45's urine soiled incontinent brief , RN-B confirmed R45's buttocks and perineal skin was moist with pink raised, grooved wrinkles over the entire area her brief had been. During an interview on 4/19/17, at 10:27 a.m. RN-C stated R45 was totally dependent on facility staff for her ADL's, and required routine changes in her position to prevent skin breakdown. She stated R45 was no longer able to verbalize her needs and she felt staff needed to anticipate R45's needs. During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs. RN-B stated R45 was at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of how long R45 had remained seated in the Broda chair and stated R45 should have been repositioned at least every 2 hours. During an interview on 4/19/17, at 10:45 a.m. NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated she was unsure why R45 was not repositioned timely.	F 314	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 interventions made, during the quarterly quality assurance meetings.	

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 314	Continued From page 22	F 314		

During an interview on 4/19/17, at 12:59 p.m. RN-A confirmed R45 was at risk for skin breakdown based on TTT and Braden scale results. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours. RN-A stated it was also the facility's standard policy to reposition at risk residents every 2 hours.

During an interview on 4/19/17, at 1:35 p.m. TMA-A stated she had assisted R45 to get up for the day at approximately 6:45 a.m. TMA-A stated she had been pulled from working as an NA that day to a TMA due to a staff member calling in ill. TMA-A stated she would usually verbally report to the other NA when a resident, such as R45, needed to be repositioned. TMA-A stated R45 was unable to verbalized her needs and required assistance with routine repositioning every 2 hours.

During an interview on 4/19/17, at 2:15 p.m. the director of nursing (DON) stated residents, such as R45, risk for skin breakdown was assessed using a TTT and Braden scale. The DON stated based on the assessments, residents were care planned with interventions to reduce the risk for skin breakdown . The DON stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated she would expect facility staff to ensure R45, who was at risk for skin breakdown, would be turned and repositioned every 2 hours.

Review of a facility policy titled, Repositioning, dated 11/2015, indicated it was the facility's policy to follow resident care plans for repositioning.

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 323	Continued From page 23	F 323		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess 1 of 2 residents (R36) observed for transfers, for safe use of the standing lift. Findings include: R36's significant change Minimum Data Set (MDS) dated 11/20/16, indicated he was severely	F 323	It is the policy and practice of Auburn Home in Waconia to ensure that the facility remains as free from accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. As noted in the surveyor's example, R36	5/30/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 cognitively impaired and required extensive assist of two staff to transfer. The MDS indicated R36 had balance that was unsteady and was unable to stabilize without assistance. A Care Area Assessment (CAA) for falls dated 11/10/16, indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The CAA indicated R36 had one fall with injury since the last assessment. The CAA for functional status dated 11/10/16, indicated R36 had weakness, decreased endurance and hemiparesis (weakness on one side of the body) that could effect transfers. R36's care plan dated 6/21/12, indicated two staff assist to transfer using a sit to stand lift. The care plan did not address the use of the lift to transport R36 from the bed to the bathroom. During observation on 4/19/17, at 7:50 a.m., R36 was transferred from the bed to the bathroom in a standing lift. Nursing assistant (NA)-B operated the lift and the director of nursing (DON) was next to R36. R36 had a sling around his back, his knees were bent and he was leaning back on the sling instead of standing upright. R36 was pushed around the end of the bed, into the entrance alcove, and into the bathroom during the transport of approximately 20 feet. The lift went over carpeted floor, over a plastic threshold, and onto the bathroom flooring. R36 was lowered onto the toilet then transferred from the toilet to a wheelchair positioned in the bathroom. The DON stated at the time of the transfer it was usual to use the standing lift to transport R36 from the bed to the bathroom with assist of 2 staff. NA-B was interviewed on 4/19/17, at 9:10 a.m., and stated the standard way to transfer R36 was	F 323	significant change MDS dated 11/20/16, indicated he required extensive assistance of two to transfer. Additionally, it referenced R36 as unsteady and unable to stabilize without assistance. A Care Area Assessment for falls dated 11/10/16 indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The surveyor notes in her example that the lift went over carpeted floor, over a plastic threshold, and onto bathroom flooring. Given the number of different flooring transitions and the resident's aforementioned impaired balance during transitions, it is the facility's position that the standing lift was the appropriate intervention and consistent with standards of practice. There were no transitions that exceeded 1/8 inch. The surveyor stated that .the /resident was transported approximately 20 feet. The actual distance was 13 feet per the facility's actually measurement of the distance. The surveyor stated that a representative for the standing lift was interviewed regarding the recommended use of the standing lift. That representative allegedly stated that the manufacturer's recommendations indicated that the lifts were designed for transferring only, not for transporting for long distances. No definition of what a 'long distance' was given. Upon review of the manufacturer's recommendations for the Volaro Stand-PA/PAS on page transferring from a chair to a commode, transferring from chair to bed, and transferring from bed to chair	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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F 323	Continued From page 25 using the standing lift "since a long time ago," and the lift was used to transport to R36 to the bathroom. She stated this was standard operating procedure in the facilty. During an interview on 4/19/17, at 10:30 a.m., registered nurse (RN-A) stated she was aware of the standing lift being used to transport R36 to the bathroom and knew of no problems with standing lift transfers and stated there were no incidents related to use of the lift in the past year. RN-A stated was not aware of an assessment for approval of the standing lift for R36. The representative for the standing lift provider was interviewed on 4/19/17, at 1:00 p.m. The representative stated the manufacturer's recommendations indicated the lifts were designed for transferring only, not for transporting for long distances. He stated the distance that was safe would be determined by the individual resident's assessment. He stated that transporting with obstructions such as turns, furniture, and over multiple flooring surfaces would also be a factor in determining risk. He stated the base legs should remain in the wide position when the resident is up in the lift which may be difficult through a doorway. Physical therapist (PT)-A was interviewed on 4/19/17, at 2:00 p.m., and stated she had seen R36 recently to increase leg strength. She stated she would do an initial assessment for residents using a standing lift, and would reassess if asked. PT-A stated she could not recall an assessment for R36 to use the standing lift but stated he had used it for a long time and no issues had been mentioned in team meetings.	F 323	are all implicated as acceptable usage of the standing lift. These examples of appropriate use of the lift are consistent with what the what the lift was being used for on 4/19/17. The resident had a comprehensive assessment on 11/7/16 compliant with the RAI process. Quarterly assessments were completed on 1/30/17 and again on 4/24/17. During these assessments, data was collected pertaining to all ADL functions including transportation. Regarding R36 transfer status, the resident has been assessed by physical therapy for appropriate lifting equipment to be used in his plan of care. The appropriate documentation supporting the intervention of using the standing lift was documented in the resident's care plan. The surveyor referenced that the facility had not defined the distance that the standing lift could be used for transport. The facility's policy is to follow the manufacturer's recommendations. Those recommendations acknowledge using the standing lift for transfers but not long transports. There is no definition of long transports. The facility includes MDS and assessment data in determining the appropriate lifting or standing device and individualizes the intervention based upon the resident's needs and abilities rather than having a specific distance defined in policy. Facility Wide Response Affecting All	

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F 323	Continued From page 26 During interview on 4/19/17, at 3:20 p.m., the DON stated the facility had not defined the distance that the standing lift could be used for transport. At 4:30 p.m., the DON stated she was not able to locate an assessment for R36's ability to use the standing lift. The manufacturer's recommendations for the standing lift "Volaro PA600/PA600S" dated 5/25/2011, directed that "Volaro lifts are designed for transferring only, not for transporting over long distances. Because the Volaro sit to stand lift was designed as an assistive device, it requires more advanced motor skills than a traditional full body lift. It is important to first determine the appropriateness of the piece of equipment for any patient." The facility policy titled Mechanical Stand and Lift Policy dated February 2017, indicated "The mechanical stand and lift should only be used for residents assessed by a licensed health professional to be appropriate for use and identified in the resident record."	F 323	Residents: 1. The facility□'s interdisciplinary team (IDT) and licensed nursing staff have been re-educated on the required resident assessnents prior to the initiation or discontinuation of mechanical stands and lifts. 2. A policy has been implemented which addresses notice of Medicare non-coverage of services documentation. 3. The rehabilitation services department will conduct the mechanical stand and lift resident assessments per the IDT's referral. 4. Ongoing: Residents utilizing mechanical stands and/or lifting equipment will be reviewed quarterly by the IDT at the quarterly care assessment, to ensure that the identified assessments have been completed. The outcome data obtained from these reviews 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 interventions made, during the quarterly quality assurance meetings.	

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	245583	A. BUILDING **02 - NEW BLDG** B. WING _____	**04/19/2017**

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

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K 000	INITIAL COMMENTS	K 000		

Swenson, Kimberly

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 19, 2017. At the time of this survey, Auburn Home in Waconia was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145

EPOC

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

Electronically Signed | 05/11/2017

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
	245583	A. BUILDING **02 - NEW BLDG** B. WING _____	**04/19/2017**

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K 000	Continued From page 1 St. Paul, MN 55101-5145, or By eMail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Auburn Home in Waconia was constructed in 2007, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 341 SS=C	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341		5/30/17

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K 341	Continued From page 2 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all kitchen staff. Findings include: On the facility tour between 08:30 am to 11:30 am on 04/19/2017 observations and staff interview revealed 3 smoke detectors with 36 inches of an HVAC diffuser in the kitchen. This deficient condition was confirmed by the Environmental Services Director	K 341	It is the intention of Auburn Home in Waconia to be in full compliance with all applicable NFPA Life Safety Code Standards. Two of the three smoke detectors have been relocated so that they are not within 36 inches of the HVAC diffuser. The third smoke detector requires an electrician to move it. All three smoke detectors cited will be relocated so that they are not within 36 inches of the HVAC diffuser by the date certain for this deficiency. In order to maintain compliance, the safety committee will conduct bi-annual facility risk management audits to ensure compliance with all applicable NFPA Life Safety Code Standards. Findings will be reported to the QA Committee and reviewed at the committee's quarterly meeting for analysis and recommendation.	

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MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 18, 2017

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5583025

Dear Mr. Krant:

The above facility was surveyed on April 17, 2017 through April 20, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Maria King, RN, APM at (507) 344-2716 or maria.king@state.mn.us.

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

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

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 17, 18, 19 and 20, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess 1 of 2 residents (R36) for safe use of the standing lift for transfers. Findings include: R36's significant change Minimum Data Set (MDS) dated 11/20/16, indicated he was severely cognitively impaired and required extensive assist of two staff to transfer. The MDS indicated R36 had balance that was unsteady and was unable to stabilize without assistance. A Care Area Assessment (CAA) for falls dated 11/10/16, indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The CAA for functional status dated 11/10/16, indicated R36 had weakness, decreased endurance and hemiparesis (weakness on one side of the body) that could effect transfers.	2 545	N/A	5/30/17

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2 545	Continued From page 3 R36's care plan dated 6/21/12, indicated two staff assist to transfer using a sit to stand lift. The care plan did not address the use of the lift to transport R36 from the bed to the bathroom. During observation on 4/19/17, at 7:50 a.m., R36 was transferred from the bed to the bathroom in a standing lift. Nursing assistant (NA)-B operated the lift and the director of nursing (DON) was next to R36. R36 had a sling around his back, his knees were bent and he was leaning back on the sling instead of standing upright. R36 was pushed around the end of the bed, into the entrance alcove, and into the bathroom during the transport of approximately 20 feet. The lift went over carpeted floor, over a plastic threshold, and onto the bathroom flooring. R36 was lowered onto the toilet then transferred from the toilet to a wheelchair positioned in the bathroom. The DON stated at the time of the transfer it was usual to use the standing lift to transport R36 from the bed to the bathroom with assist of 2 staff. NA-B was interviewed on 4/19/17, at 9:10 a.m., and stated the standard way to transfer R36 was using the standing lift "since a long time ago," and the lift was used to transport to R36 to the bathroom. She stated this was standard operating procedure in the facilty. During an interview on 4/19/17, at 10:30 a.m., registered nurse (RN-A) stated she was aware of the standing lift being used to transport R36 to the bathroom and knew of no problems with standing lift transfers and stated there were no incidents related to use of the lift in the past year. RN-A stated was not aware of an assessment for approval of the standing lift for R36.	2 545		

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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
2 545	Continued From page 4 The representative for the standing lift provider was interviewed on 4/19/17, at 1:00 p.m. The representative stated the manufacturer's recommendations indicated the lifts were designed for transferring only, not for transporting for long distances. He stated the distance that was safe would be determined by the individual resident's assessment. He stated that transporting with obstructions such as turns, furniture, and over multiple flooring surfaces would also be a factor in determining risk. He stated the base legs should remain in the wide position when the resident is up in the lift which may be difficult through a doorway. Physical therapist (PT)-A was interviewed on 4/19/17, at 2:00 p.m., and stated she had seen R36 recently to increase leg strength. She stated she would do an initial assessment for residents using a standing lift, and would reassess if asked. PT-A stated she could not recall an assessment for R36 to use the standing lift but stated he had used it for a long time and no issues had been mentioned in team meetings. During interview on 4/19/17, at 3:20 p.m., the DON stated the facility had not defined the distance that the standing lift could be used for transport. At 4:30 p.m., the DON stated she was not able to locate an assessment for R36's ability to use the standing lift. The manufacturer's recommendations for the standing lift "Volaro PA600/PA600S" dated 5/25/2011, directed that "Volaro lifts are designed for transferring only, not for transporting over long distances. Because the Volaro sit to stand lift was designed as an assistive device, it requires more advanced motor skills than a traditional full body lift. It is important to first determine the	2 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 545	Continued From page 5 appropriateness of the piece of equipment for any patient." The facility policy titled Mechanical Stand and Lift Policy dated February 2017, indicated "The mechanical stand and lift should only be used for residents assessed by a licensed health professional to be appropriate for use and identified in the resident record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring assessments are conducted as appropriate for changes in condition. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the plan of care for repositioning and personal hygiene (check and change program)	2 565	N/A	5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 565	Continued From page 6 for 1 of 2 residents (R45) reviewed for positioning and activities of daily living (ADL's.) Findings include: R45's significant change Minimum Data Set (MDS) dated 3/27/17, indicated she was severely cognitively impaired, dependent on staff for all ADL's and was always incontinent of bowel and bladder. An Auburn Home Waconia Bladder Assessment dated 3/24/17, indicated R45 was unable to recognize and respond to signals to toilet and was on a scheduled toileting program. R45's care plan dated 4/7/17, directed facility staff to assist with toileting. The care plan indicated R45 was on a Dignity Care Program (routine checking and changing for incontinence management.) The care plan did not identify a frequency for the check and change program. Continuous observation on 4/19/17, from 7:00 a.m. to 10:32 a.m., identified the following: At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed. At 7:25 a.m., R45 remained seated in the Broda chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in	2 565		

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	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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2 565	Continued From page 7	2 565		

the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required staff assistance with all cares which included routine repositioning of every 2 hours.

At 10:27 a.m., RN-C approached R45 and escorted her to the bathroom. RN-B removed R45's moderately urine soiled incontinent brief and lowered her to the toilet where she voided a large amount of urine. RN-A then left the room, and nursing assistant (NA)-A entered R45's bathroom, at that time RN-C and NA-A assisted R45 off the toilet and back into her Broda chair.

During interview on 4/19/17, at 10:27 a.m., RN-C stated R45 was totally dependent on facility staff for all ADL's and was unable to let the facility staff know of her needs, including toileting. RN-C stated R45 required every 2 hour checking and changing to manage urinary incontinence.

During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs. RN-B stated R45 was on a routine check and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 8	2 565		

changing program to manage urinary incontinence. RN-B stated R45 at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of when R45 had gotten up for the day and stated R45 should have been repositioned at least every 2 hours.

During an interview on 4/19/17, at 10:45 a.m., NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated R45 was on a every 2 hour routine check and change program for incontinence and repositioning.

During an interview on 4/19/17, at 12:59 p.m., RN-A confirmed R45 was incontinent of both bowel and bladder and was totally dependent on facility staff for toileting and hygiene. RN-A stated R45 was on a Dignity Care program which included a routine checking and changing program for incontinence management. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours and at that time she would expect facility staff to check R45's incontinence brief and change as needed.

During an interview on 4/19/17, at 1:35 p.m., TMA-A stated R45 was unable to verbalized her needs and required assistance with every 2 hour checking and changing with repositioning.

During an interview on 4/19/17, at 2:15 p.m., the director of nursing (DON) stated bowel and bladder assessments were completed quarterly for residents and based on the assessment, interventions were put into place to manage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 565	Continued From page 9 incontinence. She stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated if Dignity Care was in place for a resident, such as R45, she would expect at the time of repositioning, R45 to be checked and changed for incontinence. She further stated the facility did not have a specific policy and procedure for following a residents care plan and indicated it was an expectation all staff were aware of. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		5/30/17

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 830	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess 1 of 2 residents (R36) observed for transfers, for safe use of the standing lift. Findings include: R36's significant change Minimum Data Set (MDS) dated 11/20/16, indicated he was severely cognitively impaired and required extensive assist of two staff to transfer. The MDS indicated R36 had balance that was unsteady and was unable to stabilize without assistance. A Care Area Assessment (CAA) for falls dated 11/10/16, indicated R36 had difficulty maintaining a standing position and had impaired balance during transitions. The CAA indicated R36 had one fall with injury since the last assessment. The CAA for functional status dated 11/10/16, indicated R36 had weakness, decreased endurance and hemiparesis (weakness on one side of the body) that could effect transfers. R36's care plan dated 6/21/12, indicated two staff assist to transfer using a sit to stand lift. The care plan did not address the use of the lift to transport R36 from the bed to the bathroom. During observation on 4/19/17, at 7:50 a.m., R36 was transferred from the bed to the bathroom in a standing lift. Nursing assistant (NA)-B operated the lift and the director of nursing (DON) was next to R36. R36 had a sling around his back, his knees were bent and he was leaning back on the	2 830	N/A	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 830	Continued From page 11	2 830		

sling instead of standing upright. R36 was pushed around the end of the bed, into the entrance alcove, and into the bathroom during the transport of approximately 20 feet. The lift went over carpeted floor, over a plastic threshold, and onto the bathroom flooring. R36 was lowered onto the toilet then transferred from the toilet to a wheelchair positioned in the bathroom. The DON stated at the time of the transfer it was usual to use the standing lift to transport R36 from the bed to the bathroom with assist of 2 staff.

NA-B was interviewed on 4/19/17, at 9:10 a.m., and stated the standard way to transfer R36 was using the standing lift "since a long time ago," and the lift was used to transport to R36 to the bathroom. She stated this was standard operating procedure in the facilty.

During an interview on 4/19/17, at 10:30 a.m., registered nurse (RN-A) stated she was aware of the standing lift being used to transport R36 to the bathroom and knew of no problems with standing lift transfers and stated there were no incidents related to use of the lift in the past year. RN-A stated was not aware of an assessment for approval of the standing lift for R36.

The representative for the standing lift provider was interviewed on 4/19/17, at 1:00 p.m. The representative stated the manufacturer's recommendations indicated the lifts were designed for transferring only, not for transporting for long distances. He stated the distance that was safe would be determined by the individual resident's assessment. He stated that transporting with obstructions such as turns, furniture, and over multiple flooring surfaces would also be a factor in determining risk. He stated the base legs should remain in the wide

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AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 830	Continued From page 12 position when the resident is up in the lift which may be difficult through a doorway. Physical therapist (PT)-A was interviewed on 4/19/17, at 2:00 p.m., and stated she had seen R36 recently to increase leg strength. She stated she would do an initial assessment for residents using a standing lift, and would reassess if asked. PT-A stated she could not recall an assessment for R36 to use the standing lift but stated he had used it for a long time and no issues had been mentioned in team meetings. During interview on 4/19/17, at 3:20 p.m., the DON stated the facility had not defined the distance that the standing lift could be used for transport. At 4:30 p.m., the DON stated she was not able to locate an assessment for R36's ability to use the standing lift. The manufacturer's recommendations for the standing lift "Volaro PA600/PA600S" dated 5/25/2011, directed that "Volaro lifts are designed for transferring only, not for transporting over long distances. Because the Volaro sit to stand lift was designed as an assistive device, it requires more advanced motor skills than a traditional full body lift. It is important to first determine the appropriateness of the piece of equipment for any patient." The facility policy titled Mechanical Stand and Lift Policy dated February 2017, indicated "The mechanical stand and lift should only be used for residents assessed by a licensed health professional to be appropriate for use and identified in the resident record." SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and	2 830		

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	00053	A. BUILDING: _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 830	Continued From page 13 procedures to ensure residents receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment. The director of nursing or designee could provide review policies, provide staff education regarding polices, and audit resident records for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure timely repositioning for 1 of 1 residents (R45) reviewed for positioning and identified at risk for skin breakdown. Findings include: R45's significant change of status Minimum Data Set (MDS) dated 3/27/17, indicated she had severe cognitive impairment related to dementia. The MDS indicated she was totally dependent on	2 905	N/A	5/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 905	Continued From page 14 facility staff for all activities of daily living (ADL's) and identified a risk for pressure ulcer development. Review of a Braden Scale for Predicting Pressure Ulcer Risk, dated 3/24/17, indicated R45 was at high risk for skin breakdown based on moisture, decreased mobility, activity, nutrition, friction and shear. Review of a Tissue Tolerance Assessment (a tool used to assess risk for skin breakdown,) dated 3/24/17, identified R45 was required interventions to maintain healthy skin which included; turning and repositioning every 2 hours and a cushion in the Broda chair. Review of R45's Care Area Assessment (CAA) dated 3/27/17, indicated she was unable to verbally communicate her needs, was totally dependent on facility staff for ADL's and directed staff to anticipate her needs. The CAA revealed R45 was at high risk for skin breakdown, had a history of moisture associated skin damage (MASD) and had listed various interventions that were in place to prevent skin breakdown which included; facility staff assist to reposition every two hours, pressure relieving surfaces and added protein to her diet. R45's care plan dated 4/7/17, identified a risk for skin breakdown related to severe dementia, mobility, cognitive deficits and fragile skin. The care plan directed facility staff to turn and reposition every 2 hours from the cushioned Broda wheelchair to recliner to bed. At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed. At 7:25 a.m., R45 remained seated in the Broda	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 905	Continued From page 15	2 905		

chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required staff assistance with all cares which included routine repositioning of every 2 hours.

At 10:27 a.m., RN-C approached R45 and wheeled her into the bathroom. RN-B brought in a sit to stand mechanical lift and RN-B and RN-C assisted R45 out of the Broda chair. Upon removal of R45's urine soiled incontinent brief , RN-B confirmed R45's buttocks and perineal skin was moist with pink raised, grooved wrinkles over the entire area her brief had been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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2 905	Continued From page 16 During an interview on 4/19/17, at 10:27 a.m. RN-C stated R45 was totally dependent on facility staff for her ADL's, and required routine changes in her position to prevent skin breakdown. She stated R45 was no longer able to verbalize her needs and she felt staff needed to anticipate R45's needs. During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs. RN-B stated R45 was at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of how long R45 had remained seated in the Broda chair and stated R45 should have been repositioned at least every 2 hours. During an interview on 4/19/17, at 10:45 a.m. NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated she was unsure why R45 was not repositioned timely. During an interview on 4/19/17, at 12:59 p.m. RN-A confirmed R45 was at risk for skin breakdown based on TTT and Braden scale results. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours. RN-A stated it was also the facility's standard policy to reposition at risk residents every 2 hours. During an interview on 4/19/17, at 1:35 p.m. TMA-A stated she had assisted R45 to get up for the day at approximately 6:45 a.m. TMA-A stated she had been pulled from working as an NA that	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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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
2 905	Continued From page 17 day to a TMA due to a staff member calling in ill. TMA-A stated she would usually verbally report to the other NA when a resident, such as R45, needed to be repositioned. TMA-A stated R45 was unable to verbalized her needs and required assistance with routine repositioning every 2 hours. During an interview on 4/19/17, at 2:15 p.m. the director of nursing (DON) stated residents, such as R45, risk for skin breakdown was assessed using a TTT and Braden scale. The DON stated based on the assessments, residents were care planned with interventions to reduce the risk for skin breakdown . The DON stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated she would expect facility staff to ensure R45, who was at risk for skin breakdown, would be turned and repositioned every 2 hours. Review of a facility policy titled, Repositioning, dated 11/2015, indicated it was the facility's policy to follow resident care plans for repositioning. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they receiving the necessary treatment/services, including positioning to prevent pressure ulcers from developing. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		

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	00053	A. BUILDING: _____ B. WING _____	04/20/2017

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2 910	Continued From page 18	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a timely check and change program for urinary incontinence management for 1 of 2 residents (R45) reviewed for activities of daily living (ADL's.) Findings include: R45's significant change Minimum Data Set (MDS) dated 3/27/17, indicated she was severely cognitively impaired, dependent on staff for all ADL's and was always incontinent of bowel and bladder. Review of R45's Care Area Assessment (CAA) dated 3/27/17, indicated she was totally dependent on facility staff for ADL's, including toileting and personal hygiene and indicated she	2 910	N/A	5/30/17

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2 910	Continued From page 19	2 910		

was always incontinent of bowel and bladder and no longer used the toilet. An Auburn Home Waconia Bladder Assessment dated 3/24/17, indicated R45 was unable to recognize and respond to signals to toilet and was on a scheduled toileting program. R45's care plan dated 4/7/17, directed facility staff to assist with toileting. The care plan indicated R45 was on a Dignity Care Program (routine checking and changing for incontinence management.)

Continuous observation on 4/19/17, from 7:00 a.m. to 10:32 a.m., identified the following:

At 7:00 a.m., R45 was seated in a cushioned Broda chair (a special wheelchair used to help prevent skin breakdown) in the family room area of the neighborhood unit, a blanket covered her legs and her eyes were closed.
At 7:25 a.m., R45 remained seated in the Broda chair. Trained medication aide (TMA)-A approached R45 and administered medications from a spoon, assisted R45 to drink water and walked away. R45 had not made any independent movements. At 7:35 a.m., R45 remained seated in the Broda chair, both of her hands were on her blanket covered lap and R45 made repetitive sounds of humming and began to move both of her hands in a repetitive kneading type of motion. R45 did not move her lower body. At 8:09 a.m., R45 remained seated in the Broda chair. Registered nurse (RN)-C approached R45 and wheeled her to a dining room table. RN-C sat next to R45 and fed her breakfast. At 8:20 a.m., R45 remained seated in the Broda chair at the dining room table. At 8:59 a.m., she finished her breakfast. RN-C wheeled R45 back to the family room and put her next to the television. At 9:11 a.m., the activities director approached R45 and offered to assist her to an

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2 910	Continued From page 20 activity. The activity director escorted R45 to the chapel for newspaper reading where she remained until 10:06 a.m. R45 was then escorted back to the family room. where she remained until 10:24 a.m., at which time RN-B was notified R45 had remained in a seated position without being offered assistance with cares for 3 hours and 24 minutes. RN-B confirmed R45 required staff assistance with all cares which included routine repositioning of every 2 hours. At 10:27 a.m., RN-C approached R45 and escorted her to the bathroom. RN-B removed R45's moderately urine soiled incontinent brief and lowered her to the toilet where she voided a large amount of urine. RN-A then left the room, and nursing assistant (NA)-A entered R45's bathroom, at that time RN-C and NA-A assisted R45 off the toilet and back into her Broda chair. During interview on 4/19/17, at 10:27 a.m., RN-C stated R45 was totally dependent on facility staff for all ADL's and was unable to let the facility staff know of her needs, including toileting. RN-C stated R45 required every 2 hour checking and changing to manage urinary incontinence. During an interview on 4/19/17, at 10:37 a.m. RN-B stated R45 was not able to verbalize her needs, and staff were to anticipate her needs. RN-B stated R45 was on a routine check and changing program to manage urinary incontinence. RN-B stated R45 at risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B stated she was unsure of when R45 had gotten up for the day and stated R45 should have been repositioned at least every 2 hours.	2 910		

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2 910	Continued From page 21 During an interview on 4/19/17, at 10:45 a.m., NA-A stated she had thought R45 had been up in the Broda chair from approximately 6:45 a.m. that morning. NA-A stated R45 was dependent on staff for all cares and R45's needs were to be anticipated by staff. NA-A stated R45 was on a every 2 hour routine check and change program for incontinence and repositioning. During an interview on 4/19/17, at 12:59 p.m., RN-A confirmed R45 was incontinent of both bowel and bladder and was totally dependent on facility staff for toileting and hygiene. RN-A stated R45 was on a Dignity Care program which included a routine checking and changing program for incontinence management. RN-A confirmed R45's care plan directed facilty staff to turn and reposition every 2 hours and at that time she would expect facility staff to check R45's incontinence brief and change as needed. During an interview on 4/19/17, at 1:35 p.m., TMA-A stated she had assisted R45 to get up for the day at approximately 6:45 a.m. TMA-A stated R45 was unable to verbalized her needs and required assistance with every 2 hour checking and changing with repositioning. During an interview on 4/19/17, at 2:15 p.m., the director of nursing (DON) stated bowel and bladder assessments were completed quarterly for residents and based on the assessment, interventions were put into place to manage incontinence. She stated it was the facility's standard of practice to routinely turn and reposition residents every 2 hours to prevent skin breakdown. The DON further stated if Dignity Care was in place for a resident, such as R45, she would expect at the time of repositioning, R45 to be checked and changed for incontinence.	2 910		

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2 910	Continued From page 22 The DON stated the facility did not have a policy or procedure which addressed Dignity Care or checking and changing program for incontinence. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment/services to prevent urinary tract infections and to restore as much normal bladder function as possible.pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		