DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HZYK	
Facility ID: 00053	,

							•	
MEDICARE/MEDICAID PROV	/IDER	3. NAME AND AL	ODRESS OF FAC	CILITY		4. TYPE OF ACT	TION: 7 (L8)	
NO.(L1) 245583		(L3) AUBURN H		CONIA		1. Initial	2. Recertification	
2. STATE VENDOR OR MEDICA	AID NO.	(L4) 594 CHERR			(L6) 55387	3. Termination	4. CHOW	
(L2) 211027000		(L5) WACONIA,				5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE (OF OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey At	fter Complaint	
(L9) 6. DATE OF SURVEY	(14 4/201 5 (134)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA			
8. ACCREDITATION STATUS:	5/14/2017 ^(L34) (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR EN	DING DATE: (L35)	
0 Unaccredited 1 TJC		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
2 AOA 3 Otho								
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY		AS:	A 1/O A 1777 OC			
From (a): To (b):		X A. In Complia	equirements		And/Or Approved Waivers Of 2. Technical Personnel			
10 (b).		_	e Based On:		3. 24 Hour RN	7. Medical		
		1. A	cceptable POC		4. 7-Day RN (Rural SI			
12.Total Facility Beds	37 (L18) 37 (L17)				5. Life Safety Code	9. Beds/Roo	om	
13.Total Certified Beds	37 (L17)	B. Not in Comp Requirements	and/or Applied V		* Code:	(L12)		
14. LTC CERTIFIED BED BREAK	DOWN	-			15. FACILITY MEETS			
18 SNF 18/19 SN	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
37								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RI	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Mandalene lares	Magdalene Jares, HFE NE II 06/28/2017				.,			
- Wagaarene vares,			06/28/2017	(L19)	Kamala Fiske-Downing,	Enforcement Spe	ecialist 06/28/2017 (L20)	
F	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	COFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGI	BILITY	20. COM	IPLIANCE WITI	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible	to Participate	RIGHTS ACT:			 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Elig	ible							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOL</u>	UNTARY	
11/01/1991					01-Merger, Closure	05-Fail	to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail	to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	<u>R</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1100	vider Status Change	
(L27)	D. Doggind Co	aspension Date:	(L44)			00-Acti	ve	
	B. Rescilla Si	ispension Date.	(L45)					
20 TEDAKATANIAN DATE	20	DATE DI LEDI LEDI LEDI LEDI LEDI LEDI LEDI			20 PENADUG			
28. TERMINATION DATE:	29). INTERMEDIARY/	CAKKIEK NO.		30. REMARKS			
	,·	03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE				
	(I 22)			(1.22)	DETERMINATION ASS	DOWAL		
-	(L32)			(L33)	DETERMINATION APP	KUVAL		



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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

					AND TRANSMITTAL TE SURVEY AGENCY		ID: HZYK Facility ID: 00053
MEDICARE/MEDICAID PROVIDER	TAKI 1-	3. NAME AND AD (L3) AUBURN HO	DRESS OF FAC	CILITY	TE SURVET AGENCT	4. TYPE OF AC	<u> </u>
NO.(L1) 245583 2. STATE VENDOR OR MEDICAID NO. (L2) 211027000		(L4) 594 CHERR (L5) WACONIA ,	Y DRIVE	ONIA	(L6) 55387	1. Initial 3. Termination 5. Validation 7. On-Site Visit	 Recertification CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF OWNE (L9)		7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey A	
6. DATE OF SURVEY 04/20/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other)17 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	IDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):	7 (1.19)	10.THE FACILITY A. In Complia Program Re Compliance 1. Ac	nce With equirements	AS:	And/Or Approved Waivers 02. Technical Person3. 24 Hour RN4. 7-Day RN (Rural		f Services Limit Director
·	7 (L18) 7 (L17)	X B. Not in Com Requirements	pliance with Prog and/or Applied V	•	5. Life Safety Code * Code: B *	9. Beds/Ro (L12)	oom
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 37 (L37) (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS		. ,		DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENO	CY APPROVAL	Date:
Glenora Souther, HFE NI	ΞII	0	05/26/2017 (L19) Kamala F			g, Enforcement Sp	ecialist 06/26/2017 (L20)
PART II	- TO BE (COMPLETED E	BY HCFA RE	GIONAL	L OFFICE OR SINGLE	STATE AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particip 2. Facility is not Eligible 	ate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
	(L21)						
OF PARTICIPATION 11/01/1991	LTC AGREEN BEGINNING (L41)		ENDING DAT		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbu	00 <u>INVOI</u> 05-Fail	(L30) LUNTARY to Meet Health/Safety to Meet Agreement
25. LTC EXTENSION DATE: 27.	ALTERNATIVA. Suspension	VE SANCTIONS of Admissions: aspension Date:	(L44) (L45)		03-Risk of Involuntary Termina 04-Other Reason for Withdraw	<u>OTHE</u>	vider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
(L	28)	03001		(L31)			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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:

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

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

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

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

months after the survey date; and

<u>Informal Dispute Resolution</u> - 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

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245583	B. WING			04/	04/20/2017	
	PROVIDER OR SUPPLIER I HOME IN WACONIA			Ę	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs	F C	000				
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.						
F 156 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(d)(3)(g)(1)(4	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES	F 1	156			5/30/17	
	remains informed o of contacting the ph	nust ensure that each resident of the name, specialty, and way nysician and other primary care onsible for his or her care.						
	(1) The resident ha	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.						
	notices orally (mean	has the right to receive ning spoken) and in writing a format and a language he including:						
	The facility must fur	s as specified in this section. rnish to each resident a written rights which includes -						
	(A) A description of	the manner of protecting						
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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 A. BUILDING				E SURVEY PLETED	
		245583	B. WING			04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			594	REET ADDRESS, CITY, STATE, ZIP CODE 4 CHERRY DRIVE ACONIA, MN 55387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	personal funds, und section; (B) A description of procedures for estaincluding the right to resources under se Security Act. (C) A list of names, email), and telepho State regulatory and resident advocacy (Survey Agency, the State Long-Term Caprotection and advoservices where statin long-term care fa agency for informat community and the and (D) A statement that complaint with the Sconcerning any susfederal nursing facinot limited to reside exploitation, misappin the facility, non-cdirectives requireminformation regarding (ii) Information and and local advocacy not limited to the St. Long-Term Care Or (established under	the requirements and blishing eligibility for Medicaid, or request an assessment of ction 1924(c) of the Social addresses (mailing and ne numbers of all pertinent d informational agencies, groups such as the State State licensure office, the are Ombudsman program, the ocacy agency, adult protective e law provides for jurisdiction cilities, the local contact ion about returning to the Medicaid Fraud Control Unit; at the resident may file a State Survey Agency pected violation of state or lity regulations, including but	F 1	56			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	COMPLETED		
		245583	B. WING			04/	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			59	REET ADDRESS, CITY, STATE, ZIP CODE 04 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	U.S.C. 3001 et seq advocacy system (a as established under Disabilities Assistar 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) with November 28, 2017 (iii) Information regaligibility and covera [§483.10(g)(4)(iii) with November 28, 2017 (iv) Contact information 202(a)(20)(Act); or other No With [§483.10(g)(4)(iv) with November 28, 2017 (v) Contact information Control Unit; and [§483.10(g)(4)(v) with November 28, 2017 (vi) Information and grievances or compassion of acility regulations, resident abuse, negmisappropriation of facility, non-compliad directives requireminformation regardin (g)(5) The facility mission and (g)(6) The facility m	and the protection and as designated by the state, and as designated by the state, and as designated by the state, and are the Developmental nee and Bill of Rights Act of 001 et seq.) Ill be implemented beginning (Phase 2)] arding Medicare and Medicaid age; fill be implemented beginning (Phase 2)] ation for the Aging and Center (established under B)(iii) of the Older Americans rong Door Program; fill be implemented beginning (Phase 2)] ation for the Medicaid Fraud fill be implemented beginning (Phase 2)] at contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, resident property in the ance with the advance ents and requests for any returning to the community. The provided state of the state of the ance with the advance ents and requests for any returning to the community.	F1	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		E SURVEY MPLETED	
		245583	B. WING _		04	/20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	and telephone numagencies and advorsurvey Agency, the protective services jurisdiction in long-tof the State Long-T program, the protection and communant the Medicaid F (ii) A statement that complaint with the Sconcerning any susfederal nursing facilimited to resident a misappropriation of facility, and non-condirectives requirem I) and requests for to the community. (g)(13) The facility I written information, applicants for admininformation about hedicare and Medireceive refunds for such benefits. (g)(16) The facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that is a service to the admission and during the facility must and in writing in a later that a service th	addresses (mailing and email), bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for erm care facilities, the Office erm Care Ombudsman ction and advocacy network, ity based service programs, raud Control Unit; and the resident may file a State Survey Agency pected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or uponing the resident's stay. Inform the resident both orally anguage that the resident or her rights and all rules and	F 15	6		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245583	B. WING			04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			59	REET ADDRESS, CITY, STATE, ZIP CODE 04 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	regulations governing responsibilities during the State-developed obligations, if any. (iii) Receipt of such amendments to it, rewriting; (g)(17) The facility rewriting, at the time of facility and when the Medicaid of- (A) The items and sonursing facility serve for which the resides (B) Those other iter facility offers and for charged, and the are services; and (ii) Inform each Medicaid of the services; and (iii) Inform each Medicaid of the area of the services; and (iii) Inform each Medicaid of the area of the services; and (iii) Inform each Medicaid of the area of the services; and (iii) Inform each Medicaid of the area of the services; and (iii) Inform each Medicaid of the services; and (iii) Inform each Medicaid of the services; and	ng resident conduct and ng the stay in the facility. also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in	F1	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		JRVEY TED
		245583	B. WING		04/20/	2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA		ţ	STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CC	(X5) DMPLETION DATE
F 156	and services covery Medicaid State plan notice to residents reasonably possible (ii) Where changes items and services facility must inform 60 days prior to impose (iii) If a resident die transferred and doe facility must refund representative, or edeposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice received the resident within a date of discharge from the terms of an behalf of an individual facility must not conthese regulations. This REQUIREMED by: Based on interview facility failed to prove	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e. are made to charges for other that the facility offers, the the resident in writing at least plementation of the change. Is or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually for retained a bed in the of any minimum stay or quirements. It refund to the resident or attive any and all refunds due and days from the resident's from the facility. Cadmission contract by or on the facility admission to the neflict with the requirements of the new of any document review, the wide the appropriate notices for the organized in the facility who remained in the facility	F 156	It is the policy, and intention, of Authome in Waconia to be in full compwith all regulations and requirement both the Medicaid and Medicare programs. These plans and respon	oliance is of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245583	B. WING			04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			59	TREET ADDRESS, CITY, STATE, ZIP CODE 94 CHERRY DRIVE /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	1/2/17, for a coveraremained in the the determination of conceptual determination of c	ce of Medicare Non-Coverage ge end date of 1/4/17. R9 facility, but did not receive a ntinued stay. on 4/19/17, at 3:22 p.m., sentative (SS)-A stated R9's was terminated because the ave the days." She stated R9 ility for possible end of life. erapy was re-instated on used until 1/27/17 when her SS-A stated the facility of non coverage, but had not nination of continued stay and ware of the form. 4/19/17, at 4:05 p.m., the did he was no aware of what given, but he expected the	F 1	56	the findings are written solely to macertification in the Medicare and Me Programs and, as required, are sut as the facility SCREDIBLE ALLEGOF COMPLIANCE. This written response does not con an admission of noncompliance wit requirement. Submission of this Pl Correction is not an admission that deficiency exists or that one was ci correctly. We wish to preserve our dispute these findings in their entire should any remedies be imposed. The scenario reflected in the exam rare occurrence at Auburn Home. contributed to SS-A's unfamiliarity of form resulting in R9 not receiving it During the survey, SS-A contacted another of our skilled care facilities reoriented herself on the determination continued stay form referenced in the example. That form was immediate into practice. Facility Wide Response Affecting A Residents: 1. The facility is interdisciplinary (IDT) and social service staff have educated on the required determination requirements for residents who have accessing their skilled nursing Med Benefits and are no longer coverables. 3. Ongoing: Quarterly random satisficial continued stay documents and are no longer coverables.	edicaid omitted CATION astitute th any lan of a ted right to ety ple is a This with the . and ation of he ely put ll team been ation of ve been licare ole.	

CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245583	B. WING		04/2	20/2017	
ROVIDER OR SUPPLIER HOME IN WACONIA		59	94 CHERRY DRIVE			
(EACH DEFICIENCY	EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
		F 156	their Medicare Skilled Nursing Care Benefit will be conducted utilizing the QIS Demand Billing auditing tool to ensure compliance with the require at F 156. These audits will be condast part of the facility'□s quality assimitative for not less than one year, obtained from the quality assurance process will be reviewed, with recommendations for interventions	ments ducted urance Data e made,	5/30/17	
(b)(2)(ii) Within 14 determines, or show there has been a sine resident's physical opurpose of this sect means a major decresident's status the itself without further implementing standinterventions, that hone area of the resident's interdisciplicate plan, or both.) This REQUIREMENT by: Based on observative review the facility facili	days after the facility ald have determined, that gnificant change in the or mental condition. (For tion, a "significant change" line or improvement in the at will not normally resolve intervention by staff or by lard disease-related clinical has an impact on more than dent's health status, and inary review or revision of the NT is not met as evidenced ion, interview, and document alled to comprehensively ents (R36) for safe use of the		Home in Waconia to comprehensivassess residents when a significan change in a resident's physical or noting condition has been identified. These	rely t nental se	3/30/11	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa 483.20(b)(2)(ii) COI AFTER SIGNIFICA (b)(2)(ii) Within 14 determines, or shouthere has been a siresident's physical opurpose of this sectimeans a major decresident's status that itself without further implementing standinterventions, that hone area of the resirequires interdisciplicate plan, or both.) This REQUIREMENT by: Based on observator review the facility faces assess 1 of 2 residenty or contents.	HOME IN WACONIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 Continued From page 7 A83.20(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.	AND A CONTIDER ON SUPPLIER HOME IN WACONIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 F 156 F 274 A83.20(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.	HOME IN WACONIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 F 156 F 156 F 156 F 156 F 156 T	STREET ADDRESS, CITY, STATE, ZIP CODE 94 CHERRY DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 F 156 Continued From page 7 F 254 Continued From page 7 F 256 Continued From page 7 F 274 Continued From page 7 F 274 Continued From page 7 F 274 Continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	TIPLE CONSTRUCTION ING		E SURVEY IPLETED	
		245583	B. WING		04/	04/20/2017	
NAME OF	PROVIDER OR SUPPLIER	2-1000		STREET ADDRESS, CITY, STATE, ZIP CODE		20/2017	
	I HOME IN WACONIA	1		594 CHERRY DRIVE WACONIA, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 274	R36's significant cl (MDS) dated 11/20 cognitively impaire of two staff to transhad balance that we to stabilize without Assessment (CAA indicated R36 had standing position aduring transitions, dated 11/10/16, indecreased endural (weakness on one effect transfers. R36's care plan dates assist to transfer uplan did not addres R36 from the bed to During observation was transferred frostanding lift. Nursing the lift and the director R36. R36 had a knees were bent a sling instead of standing instead of standing to the bathroom onto the bathroom onto the bathroom onto the toilet then wheelchair position stated at the time of use the standing lift to the bathroom with the ba	nange Minimum Data Set /16, indicated he was severely d and required extensive assist afer. The MDS indicated R36 has unsteady and was unable assistance. A Care Area of for falls dated 11/10/16, difficulty maintaining a nd had impaired balance. The CAA for functional status licated R36 had weakness, note and hemiparesis side of the body) that could sted 6/21/12, indicated two staffesting a sit to stand lift. The care as the use of the lift to transport to the bathroom. I on 4/19/17, at 7:50 a.m., R36 and the bed to the bathroom in a negassistant (NA)-B operated cor of nursing (DON) was next sling around his back, his nd he was leaning back on the nding upright. R36 was pushed the bed, into the entrance be bathroom during the simately 20 feet. The lift went of the company of the transferred from the toilet to a need in the bathroom. The DON of the transfer it was usual to to transport R36 from the bed	F 2	As noted in the surveyor's exar significant change MDS dated indicated he required extensive assistance of two to transfer. A it referenced R36 as unsteady to stabilize without assistance. Area Assessment for falls date indicated R36 had difficulty ma standing position and had impabalance during transitions. The notes in her example that the li over carpeted floor, over a plas threshold, and onto bathroom f Given the number of different f transitions and the resident's aforementioned impaired balar transitions, it is the facility's posthe standing lift was the approprintervention and consistent with of practice. The carpeted floor plastic threshold, and onto the flooring transitions that the surverferenced do not exceeded 1/ The surveyor stated that the retransported approximately 20 fractual distance was 13 feet perfacility's actually measurement distance. The surveyor stated that a representative standing lift. That representative standing lift. That representative stated that the manufacturer's recommendations indicated that were designed for transferring for transporting for long distance.	dditionally, and unable A Care d 11/10/16 intaining a ired e surveyor ft went tic looring. ooring ice during sition that iriate in standards over a bathroom reyor a inch. sident was eet. The of the esentative wed se of the e allegedly at the lifts only, not		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	` '	E SURVEY PLETED
		245583	B. WING _		04/	20/2017
_	PROVIDER OR SUPPLIER I HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP COE 594 CHERRY DRIVE WACONIA, MN 55387	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 274	using the standing the lift was used to bathroom. She stat procedure in the factor of the standing lift being the standing lift transference incidents related to RN-A stated was not approval of the standing lift transference incidents related to RN-A stated was not approval of the standing lift transference incidents related to RN-A stated was not approval of the standing lift transference incidents related to RN-A stated was not approval of the standing lift recommendations it designed for transference for long distances. Was safe would be resident's assessmit transporting with obtainiture, and over would also be a fact stated the base leg position when the remay be difficult through the standing lift lift recommendations in the standing lift lift lift lift lift lift lift lift	dard way to transfer R36 was lift "since a long time ago," and transport to R36 to the ed this was standard operating cilty. on 4/19/17, at 10:30 a.m., (N-A) stated she was aware of an used to transport R36 to knew of no problems with rs and stated there were no use of the lift in the past year. It aware of an assessment for ading lift for R36. for the standing lift provider 4/19/17, at 1:00 p.m. The ed the manufacturer's andicated the lifts were erring only, not for transporting the stated the distance that determined by the individual ent. He stated that astructions such as turns, multiple flooring surfaces for in determining risk. He is should remain in the wide esident is up in the lift which ough a doorway. PT)-A was interviewed on an and stated she had seen rease leg strength. She stated tial assessment for residents and would reassess if asked. Und not recall an assessment standing lift but stated he had me and no issues had been	F 27	definition of what a 'long dista given. Upon review of the ma recommendations for the Vola PA/PAS on page 6 of the Ope Manual, transferring from a chand transferring from bed to a implicated as acceptable usage standing lift. These examples appropriate use of the lift are with what the lift was being us 4/19/17. Actual verbiage on particle of the lift was being us 4/19/17. Actual verbiage on particle of the lift was being us 4/19/17. Actual verbiage on particle of the lift was being us 4/19/17. Actual verbiage on particle of the lift was being us 4/19/17. Actual verbiage on particle of the lift was being us 4/19/17. Actual verbiage on particle of lift was being us 4/19/17. The resident had a comprehe assessment on 11/7/16 comparting Manual. The resident had a comprehe assessment on 11/7/16 comparting Manual. The resident had a comprehe assessment on 1/30/17 ar 4/24/17. During these assess was collected pertaining to all functions including transferring mobility. Regarding R36 transfer status resident has been assessed by the used in his plan of care. The appropriate documentation suintervention of using the stand documented in the resident's appropriate documentation suintervention of using the stand documented in the resident's appropriate documentation suintervention of using the stand documented in the resident's appropriate documentation suintervention of using the stand documented in the resident's appropriate documentation suintervention of using the stand documented in the resident's appropriate documentation suintervention of using the stand documented in the resident's appropriate documented in th	nufacturer's aro Stand-rator's hair to a hair to bed, hair are all ge of the consistent ed for on age 6 of the bw that the ear of chair, a to the lity staff rer's ensive liant with the sments and again on ments, data ADL g and s, the by physical equipment to he pporting the ling lift was care plan.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245583	B. WING		04/20/201	7
	PROVIDER OR SUPPLIER I HOME IN WACONIA		5	STREET ADDRESS, CITY, STATE, ZIP CODE 194 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPL	ETION
F 274	DON stated the fact distance that the statement and the statement and to use the standing. The manufacturer's standing lift "Volaro 5/25/2011, directed for transferring only distances. Because designed as an assadvanced motor sk lift. It is important to appropriateness of patient." The facility policy tit Policy dated Februa mechanical stand a residents assessed	4/19/17, at 3:20 p.m., the ility had not defined the anding lift could be used for .m., the DON stated she was a assessment for R36's ability lift. If recommendations for the PA600/PA600S" dated that "Volaro lifts are designed that "Volaro lifts are designed that volaro sit to stand lift was sistive device, it requires more ills than a traditional full body of first determine the the piece of equipment for any cled Mechanical Stand and Lift ary 2017, indicated "The and lift should only be used for by a licensed health appropriate for use and	F 274	 The facility is interdisciplinary (IDT) and licensed nursing staff hat been re-educated on the required rassessnents prior to the initiation of discontinuation of mechanical stantifts. The rehabilitation services department will conduct the mechastand and lift resident assessments part of the RAI Comprehensive or Significant Change Assessments p Ongoing: Residents utilizing mechanical stands and/or lifting equipment will be reviewed quarter the IDT at the quarterly care assess to ensure that the identified assess have been completed. The outcon obtained from these reviews will be conducted as part of the facility is assurance initiative for not less that year. Data obtained from the quality assurance process will be reviewed recommendations for interventions during the quarterly quality assurance. 	ve esident r ds and nical s as rocess. ly by sment, ments he data quality n one by d, with made,	
F 282 SS=D	PERSONS/PER CA (b)(3) Comprehens The services provid as outlined by the c must- (ii) Be provided by c	ive Care Plans led or arranged by the facility, omprehensive care plan,	F 282	meetings.	5/30/1	17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245583	B. WING		04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA		5	STREET ADDRESS, CITY, STATE, ZIP CODE 194 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	by: Based on observareview the facility fadirected by the plar personal hygiene (of or 1 of 2 residents and activities of dail Findings include: R45's significant of (MDS) dated 3/27/2 cognitively impaired ADL's and was alw bladder. An Auburn Assessment dated unable to recognize toilet and was on a R45's care plan dail to assist with toiletin R45 was on a Dignic checking and chan management.) The frequency for the of Continuous observation. At 7:00 a.m., R45 was on the regular of the neighborhood legs and her eyes was an	NT is not met as evidenced tion, interview and document ailed to provide services as not care for repositioning and check and change program) (R45) reviewed for positioning ly living (ADL's.) Thange Minimum Data Set 17, indicated she was severely d, dependent on staff for all vays incontinent of bowel and Home Waconia Bladder 3/24/17, indicated R45 was and respond to signals to scheduled toileting program. Set 4/7/17, directed facility staffing. The care plan indicated ity Care Program (routine ging for incontinence care plan did not identify a neck and change program. Tation on 4/19/17, from 7:00 identified the following: The seated in a cushioned cial wheelchair used to help down) in the family room area do unit, a blanket covered her	F 282	The services provided or arranged Auburn Home in Waconia, as outling the comprehensive care plan, is proby qualified persons in accordance each resident's written plan of care. In the example cited by the survey was involved in a planned activity of morning of 4/19/17. The extended of her repositioning and incontinent check was the outcome of miscommunication between facility and the resident participating in meaningful activities during the obstime period referenced by the survent The resident's care plan was reviet ensure every two hour repositionin incontinence checks are included. addition, the frequency of positionin changes and incontinence checks been emphasized on the nursing a care worksheets. Facility Wide Response Affecting Aresidents: 1. The facility service Resident Reposand Incontinence Monitoring Policy been revised to include verbiage addressing the facility's standard enterpositioning and incontinence monitoring requirement for resident unable to reposition themselves are incontinent residents. The policy addresses that every resident will here.	ned by ovided by ovided by with by ovided by staff served by served by and ling has satisfant by over 2	

CENTER	<u> 15 FOR MEDICARE</u>	& MEDICAID SERVICES			<u> </u>	MB MO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
		245583	B. WING			04/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	I HOME IN WACONIA				94 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	walked away. R45 I independent mover remained seated in hands were on her made repetitive sout to move both of her kneading type of m lower body. At 8:09 the Broda chair. Reapproached R45 ar room table. RN-C s breakfast. At 8:20 at the Broda chair at ta.m., she finished hR45 back to the far the television. At 9: approached R45 ar activity. The activity chapel for newspap remained until 10:0 back to the family runtil 10:24 a.m., at R45 had remained being offered assis and 24 minutes. RN staff assistance wit routine repositionin. At 10:27 a.m., RN-escorted her to the R45's moderately that and lowered her to large amount of uriting and nursing assistate bathroom, at that tin R45 off the toilet ar.	ments. At 7:35 a.m., R45 the Broda chair, both of her blanket covered lap and R45 unds of humming and began r hands in a repetitive otion. R45 did not move her a.m., R45 remained seated in registered nurse (RN)-C and wheeled her to a dining reat next to R45 and fed her a.m., R45 remained seated in registered nurse (RN)-C and wheeled her to a dining reat next to R45 and fed her a.m., R45 remained seated in the dining room table. At 8:59 her breakfast. RN-C wheeled mily room and put her next to 11 a.m., the activities director and offered to assist her to an redirector escorted R45 to the there are along where she 6 a.m. R45 was then escorted from. where she remained which time RN-B was notified in a seated position without tance with cares for 3 hours N-B confirmed R45 required the all cares which included g of every 2 hours. C approached R45 and bathroom. RN-B removed urine soiled incontinent brief the toilet where she voided a ne. RN-A then left the room, ant (NA)-A entered R45's me RN-C and NA-A assisted and back into her Broda chair. 4/19/17, at 10:27 a.m., RN-C	F 2	282	individualized repositioning and bat plan of care based upon the resider comprehensive assessment. 2. Staff education consisted of a and Sign' education module which addressed resident repositioning an incontinence monitoring. The modi included the following: "Please rem to always review the NAR workshed binder prior to your work shift to be that you are aware of any changes residents prior to beginning any car The NAR binder and treatment boo also be flagged with a red paper withose residents requiring turning an repositioning or off loading per exce of the standard of 2 hours. All residents plan of care information pertinent to providing care is located the NAR worksheet. Staff are requificated to provide the NAR worksheet or ask the nurse for direction." 3. Ongoing: Quarterly random sate audits of residents who are unablated to the number of the standard of the standard of the standard of the standard of the number of the standard of the number of the standard of the number of the standard of the standard of the number of the standard of the number of the standard of the standard of the standard of the number of the standard	rit's 'Read I'Read I'Read	
		ally dependent on facility staff			during the quarterly quality assuran	,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245583	B. WING		····	04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			5	TREET ADDRESS, CITY, STATE, ZIP CODE 94 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	for all ADL's and waknow of her needs, stated R45 required changing to manage During an interview RN-B stated R45 where RN-B breakdown and was history of skin breakdown and grineal area. RN-E when R45 had gotte R45 should have be a hours. During an interview NA-A stated she had the Broda chair from morning. NA-A stated staff for all cares are anticipated by staff, every 2 hour routing for incontinence and During an interview RN-A confirmed R45 was on a Dignincluded a routine of program for incontine confirmed R45's caturn and reposition she would expect face.	as unable to let the facility staff including toileting. RN-C devery 2 hour checking and e urinary incontinence. on 4/19/17, at 10:37 a.m. as not able to verbalize here to anticipate her needs. was on a routine check and to manage urinary stated R45 at risk for skin sunaware if R45 had any kdown of her buttocks or a stated she was unsure of en up for the day and stated een repositioned at least every on 4/19/17, at 10:45 a.m., d thought R45 had been up in mapproximately 6:45 a.m. that ed R45 was dependent on and R45's needs were to be NA-A stated R45 was on a e check and change program	F 2	282	meetings.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245583	B. WING _		04/20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 312 SS=D	During an interview TMA-A stated R45 needs and required checking and chan During an interview director of nursing bladder assessment for residents and be interventions were incontinence. She standard of practice reposition residents breakdown. The DC Care was in place to she would expect a R45 to be checked She further stated specific policy and residents care plant expectation all staff 483.24(a)(2) ADL CDEPENDENT RESCONDENT	on 4/19/17, at 1:35 p.m., was unable to verbalized her assistance with every 2 hour ging with repositioning. on 4/19/17, at 2:15 p.m., the (DON) stated bowel and assessment, put into place to manage stated it was the facility's to routinely turn and severy 2 hours to prevent skin DN further stated if Dignity for a resident, such as R45, at the time of repositioning, and changed for incontinence. The facility did not have a procedure for following a and indicated it was an and indi	F 28		ents es of to and when a

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245583	B. WING			04/	20/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	J 04/2	20/2017
AUBURN	N HOME IN WACONIA	1			94 CHERRY DRIVE /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	R45's significant of (MDS) dated 3/27/cognitively impaire ADL's and was all bladder. Review of (CAA) dated 3/27/dependent on facil toileting and perso was always incontino longer used the Waconia Bladder A indicated R45 was respond to signals scheduled toileting dated 4/7/17, directoileting. The care Dignity Care Progreschanging for inconton Continuous observa.m. to 10:32 a.m. At 7:00 a.m., R45 and Broda chair (a speprevent skin break of the neighborhoolegs and her eyes At 7:25 a.m., R45 and her eyes At 7:25 a.m.	change Minimum Data Set 17, indicated she was severely d, dependent on staff for all ways incontinent of bowel and R45's Care Area Assessment 17, indicated she was totally ity staff for ADL's, including nal hygiene and indicated she ment of bowel and bladder and totilet. An Auburn Home Assessment dated 3/24/17, unable to recognize and to toilet and was on a program. R45's care plan sted facility staff to assist with plan indicated R45 was on a am (routine checking and tinence management.) vation on 4/19/17, from 7:00 , identified the following: was seated in a cushioned cial wheelchair used to help down) in the family room area od unit, a blanket covered her were closed. remained seated in the Broda dication aide (TMA)-A nd administered medications sted R45 to drink water and	F3	112	or mental condition has been ident These assessments include an Interdisciplinary Team (IDT) approate the analysis of all assessment collected and analysis of all assessment collected and incontinent check was the outcome of miscommunication between facility and the resident participating in meaningful activities during the obstime period referenced by the survers and the resident's care plan was reviewen ensure every two hour repositioning incontinence checks are included. addition, the frequency of positioning changes and incontinence checks been emphasized on the nursing a resident care cards. Facility Wide Response Affecting A Residents: 1. The facility is Resident Reposs and Incontinence Monitoring Policy been revised to include verbiage addressing the facility's standard e hour repositioning and incontinence monitoring requirement for resident unable to reposition themselves and incontinent residents. The policy and addresses that every resident will be individualized repositioning and bat plan of care based upon the resident comprehensive assessment.	ach in ected or, R45 on the period ce staff served eyor. wed to g and In ag has ssistant Il itioning has very 2 et s d for Iso lave an throom	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245583	B. WING			04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			59	TREET ADDRESS, CITY, STATE, ZIP CODE 94 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	the Broda chair. Reapproached R45 ar room table. RN-C sheakfast. At 8:20 at the Broda chair at ta.m., she finished has the television. At 9: approached R45 ar activity. The activity chapel for newspaper remained until 10:00 back to the family runtil 10:24 a.m., at R45 had remained being offered assis and 24 minutes. Rh staff assistance wit routine repositionin At 10:27 a.m., RN-escorted her to the R45's moderately and lowered her to large amount of uri and nursing assistate bathroom, at that til R45 off the toilet ar During interview on stated R45 was totated R45 was totated R45 required changing to manage. During an interview on stated R45 required changing to manage.	registered nurse (RN)-C and wheeled her to a dining that next to R45 and fed her a.m., R45 remained seated in the dining room table. At 8:59 the breakfast. RN-C wheeled mily room and put her next to 11 a.m., the activities director and offered to assist her to an ordirector escorted R45 to the oper reading where she 6 a.m. R45 was then escorted which time RN-B was notified in a seated position without tance with cares for 3 hours N-B confirmed R45 required th all cares which included	F3	312	2. Staff education consisted of a and Sign' education module which addressed resident repositioning a incontinence monitoring. The modincluded the following: "Please rento always review the NAR workshebinder prior to your work shift to be that you are aware of any changes residents prior to beginning any car. The NAR binder and treatment boo also be flagged with a red paper withose residents requiring turning ar repositioning or off loading per excoft the standard of 2 hours. All residents plan of care information pertinent to providing care is located the NAR worksheet. Staff are requifollow the NAR worksheet or ask thourse for direction." 3. Ongoing: Quarterly random satudits of residents who are unable reposition themselves, and/or are incontinent, will consist of observating the time between repositioning and incontinence monitoring to ensure not in excess of every 2 hours or as individualized plan of care indicates the resident. These audits will be conducted as part of the facility' sasurance initiative for not less that year. Data obtained from the quality assurance process will be reviewed recommendations for interventions during the quarterly quality assurance meetings.	nd ule nember et and sure in your res. ok will th nd eption on d on red to ne ions of that it is s the s for quality n one ty d, with made,	

needs, and staff were to anticipate her needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245583	B. WING		04	/20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZI 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	RN-B stated R45 v changing program incontinence. RN-E breakdown and wa history of skin breaperineal area. RN-I when R45 had gott R45 should have b 2 hours. During an interview NA-A stated she hat the Broda chair from morning. NA-A statestaff for all cares an anticipated by staff every 2 hour routing for incontinence and During an interview RN-A confirmed R45 was on a Dignincluded a routine of program for incontinence program for incontinence brief and During an interview R45 was unable to required assistance and changing with	was on a routine check and to manage urinary a stated R45 at risk for skin is unaware if R45 had any kdown of her buttocks or a stated she was unsure of en up for the day and stated een repositioned at least every of on 4/19/17, at 10:45 a.m., and thought R45 had been up in approximately 6:45 a.m. that ed R45 was dependent on and R45's needs were to be. NA-A stated R45 was on a neighbor check and change program and repositioning. If on 4/19/17, at 12:59 p.m., as was incontinent of both and was totally dependent on the checking and changing nence management. RN-A stated ity Care program which checking and changing nence management. RN-A are plan directed facility staff to every 2 hours and at that time acility staff to check R45's and change as needed. If on 4/19/17, at 1:35 p.m., and assisted R45 to get up for nately 6:45 a.m. TMA-A stated verbalized her needs and a with every 2 hour checking		312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245583	B. WING _		04/:	20/2017
	PROVIDER OR SUPPLIER HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 SS=D	bladder assessment for residents and basinterventions were princontinence. She is standard of practice reposition residents breakdown. The DC Care was in place for she would expect at R45 to be checked. The DON stated the or procedure which checking and changed 483.25(b)(1) TREAT PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive assess facility must ensure. (i) A resident receive professional standary pressure ulcers and ulcers unless the indemonstrates that the comprehensional standary pressure ulcers and ulcers unless the indemonstrates that the comprehensional standary pressional standary pres	DON) stated bowel and ats were completed quarterly ased on the assessment, but into place to manage stated it was the facility's at to routinely turn and a every 2 hours to prevent skin DN further stated if Dignity or a resident, such as R45, and changed for incontinence. A facility did not have a policy addressed Dignity Care or ging program for incontinence. TMENT/SVCS TO RESSURE SORES	F 3		Home	5/30/17
	. 57.617 the racinty ra			accession of a resident, rabuit	.50	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY PLETED
		245583	B. WING		04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 19	F 314			
	for positioning and breakdown. Findings include:	of 1 residents (R45) reviewed identified at risk for skin		in Waconia's standard of practice that residents receive care, consist with professional standards of praprevent pressure ulcers and do not develop pressure ulcers unless the individual □'s clinical condition	stent ctice, to ot e	
	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 skip broakdown			In the example cited by the survey was involved in a planned activity morning of 4/19/17. The extended of her repositioning and incontined check was the outcome of	or, R45 on the d period	
	based on moisture nutrition, friction ar Tolerance Assessn risk for skin breakd identified R45 was maintain healthy sk	R45 was at high risk for skin breakdown moisture, decreased mobility, activity, riction and shear. Review of a Tissue Assessment (a tool used to assess in breakdown,) dated 3/24/17, R45 was required interventions to nealthy skin which included; turning and ing every 2 hours and a cushion in the		miscommunication between facilit and the resident participating in meaningful activities during the obtime period referenced by the sure. The resident's care plan was revie ensure every two hour repositioning incontinence checks are included addition, the frequency of position changes and incontinence checks.	ewed to ng and In	
	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,			been emphasized on the nursing a resident care cards. Facility Wide Response Affecting Residents: 1. The facility 's Resident Report and Incontinence Monitoring Police been revised to include verbiage addressing the facility's standard of the hour repositioning and incontinent monitoring requirement for resident unable to reposition themselves a incontinent residents. The policy addresses that every resident will	All sitioning y has every 2 ce nts nd for also	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245583	B. WING			04/2	20/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				5	94 CHERRY DRIVE		
AUBURN	I HOME IN WACONIA			٧	VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 20	F 3	14			
	mobility, cognitive d	eficits and fragile skin. The acility staff to turn and ours from the cushioned			individualized repositioning and bat plan of care based upon the reside comprehensive assessment.	nt's	
	At 7:00 a.m., R45 w Broda chair (a spector of the neighborhood legs and her eyes w At 7:25 a.m., R45 rechair. Trained mediapproached R45 arfrom a spoon, assis walked away. R45 hindependent mover remained seated in hands were on her made repetitive souto move both of her kneading type of molower body. At 8:09 the Broda chair. Re	vas seated in a cushioned ial wheelchair used to help lown) in the family room area dunit, a blanket covered her vere closed. emained seated in the Broda cation aide (TMA)-A and administered medications sted R45 to drink water and had not made any ments. At 7:35 a.m., R45 the Broda chair, both of her blanket covered lap and R45 ands of humming and began hands in a repetitive otion. R45 did not move her a.m., R45 remained seated in gistered nurse (RN)-C			2. Staff education consisted of a and Sign' education module which addressed resident repositioning at incontinence monitoring. The mod included the following: "Please ren to always review the NAR workshe binder prior to your work shift to be that you are aware of any changes residents prior to beginning any car. The NAR binder and treatment boo also be flagged with a red paper withose residents requiring turning ar repositioning or off loading per except of the standard of 2 hours. All residents plan of care information pertinent to providing care is located the NAR worksheet. Staff are requifollow the NAR worksheet or ask the nurse for direction."	nd ule nember et and sure in your res. ok will th nd eption on d on red to	
	room table. RN-C s breakfast. At 8:20 a the Broda chair at the a.m., she finished he R45 back to the fand the television. At 9: approached R45 ar activity. The activity chapel for newspaper remained until 10:0 back to the family requited to the family required to the family	at wheeled her to a dining at next to R45 and fed her a.m., R45 remained seated in the dining room table. At 8:59 there breakfast. RN-C wheeled willy room and put her next to an additional offered to assist her to an additional director escorted R45 to the there reading where she a.m. R45 was then escorted boom, where she remained which time RN-B was notified in a seated position without cance with cares for 3 hours I-B confirmed R45 required			 All nursing assistant staff will assigned a skin integrity and press ulcer prevention learning module of facility's on-line continuing education learning program. Ongoing: Quarterly random satudits of residents who are unable reposition themselves, and/or are incontinent, will consist of observation the time between repositioning and incontinence monitoring to ensure not in excess of every 2 hours or as individualized plan of care indicates the resident. These audits will be 	ure in the on imple e to ions of that it is s the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
		245583	B. WING _		04/:	20/2017		
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 314	staff assistance with routine repositioning. At 10:27 a.m., RN-0 wheeled her into the sit to stand mechan assisted R45 out of removal of R45's ur RN-B confirmed R4 was moist with pink the entire area her library by the entire libr	all cares which included g of every 2 hours. C approached R45 and e bathroom. RN-B brought in a ical lift and RN-B and RN-C the Broda chair. Upon ine soiled incontinent brief, .5's buttocks and perineal skin raised, grooved wrinkles over brief had been. on 4/19/17, at 10:27 a.m. as totally dependent on facility and required routine changes event skin breakdown. She longer able to verbalize her staff needed to anticipate on 4/19/17, at 10:37 a.m. as not able to verbalize her re to anticipate her needs. Vas at risk for skin breakdown R45 had any history of skin uttocks or perineal area. RN-B ure of how long R45 had the Broda chair and stated een repositioned at least every on 4/19/17, at 10:45 a.m. d thought R45 had been up in approximately 6:45 a.m. that ed R45 was dependent on and R45's needs were to be NA-A stated she was unsure	F 3	conducted as part of the faci assurance initiative for not le year. Data obtained from the assurance process will be re recommendations for interveduring the quarterly quality a meetings.	ess than one e quality eviewed, with entions made,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245583	B. WING		04/	/20/2017
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA				STREET ADDRESS, CITY, STATE, ZIP 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 CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	During an interview RN-A confirmed R4 breakdown based or results. RN-A confir facilty staff to turn a RN-A stated it was policy to reposition hours. During an interview TMA-A stated she if the day at approximate had been pulled day to a TMA due to TMA-A stated she with the other NA when needed to be reposition was unable to verbassistance with rour hours. During an interview director of nursing (as R45, risk for skir using a TTT and Britansed on the assest planned with interves kin breakdown. The facility's standard or reposition residents breakdown. The Doexpect facility staff risk for skin breakdore every stated in the stated she with the position of a facility dated 11/2015, indicated indicated in the stated or reposition of a facility dated 11/2015, indicated in the stated or reposition of a facility dated 11/2015, indicated in the stated or reposition of a facility dated 11/2015, indicated in the stated or residents breakdown.	on 4/19/17, at 12:59 p.m. 5 was at risk for skin on TTT and Braden scale rmed R45's care plan directed and reposition every 2 hours. also the facility's standard at risk residents every 2 on 4/19/17, at 1:35 p.m. had assisted R45 to get up for hately 6:45 a.m. TMA-A stated d from working as an NA that to a staff member calling in ill. would usually verbally report to a resident, such as R45, hitioned. TMA-A stated R45 halized her needs and required tine repositioning every 2 on 4/19/17, at 2:15 p.m. the pDON) stated residents, such his breakdown was assessed haden scale. The DON stated her needs and required tine repositioning every 2 on 4/19/17, at 2:15 p.m. the pDON) stated residents, such his breakdown was assessed haden scale. The DON stated her practice to routinely turn and his every 2 hours to prevent skin his properties of the residents was at his prope	F 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245583	B. WING			04/20/2017	
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA				59	TREET ADDRESS, CITY, STATE, ZIP CODE 04 CHERRY DRIVE VACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 323 SS=D	HAZARDS/SUPER (d) Accidents.	1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 3				5/30/17
	The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and						
		eceives adequate supervision ices to prevent accidents.					
	appropriate alternation bed rail. If a bed or must ensure correct	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and drails, including but not limited ments.					
	(1) Assess the residence from bed rails prior	dent for risk of entrapment to installation.					
		s and benefits of bed rails with dent representative and obtain rior to installation.					
	appropriate for the This REQUIREMENT by: Based on observative review the facility factors assess 1 of 2 resident.	bed's dimensions are resident's size and weight. NT is not met as evidenced tion, interview, and document alled to comprehensively ents (R36) observed for use of the standing lift.			It is the policy and practice of Aubu Home in Waconia to ensure that the facility remains as free from accide hazards as possible and that each resident receives adequate supervi and assistance devices to prevent	e nt	
		ange Minimum Data Set /16, indicated he was severely			accidents. As noted in the surveyor's example	, R36	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245583	B. WING			04/2	20/2017	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		-0,-011	
				5	94 CHERRY DRIVE			
AUBURN	I HOME IN WACONIA			٧	VACONIA, MN 55387			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IOULD BE COM		
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		F3	significant change MDS dated 11/20/16 indicated he required extensive assistance of two to transfer. Additional it referenced R36 as unsteady and unato stabilize without assistance. A Care Area Assessment for falls dated 11/10/indicated R36 had difficulty maintaining standing position and had impaired balance during transitions. The survey 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 standard of practice. There were no transitions 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 representation the standing lift was interviewed regarding the recommended use of the standing lift. That representative allege stated that the manufacturer's				
	onto the toilet then wheelchair position stated at the time of use the standing lift to the bathroom with NA-B was interview	transferred from the toilet to a ed in the bathroom. The DON of the transfer it was usual to to transport R36 from the bed			recommendations indicated that the were designed for transferring only, for transporting for long distances. definition of what a 'long distance' we given. Upon review of the manufact recommendations for the Volaro Stansferring from the a commode, transferring from the bed, and transferring from bed to che	not No vas sturer's and- a chair air to		

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

` '	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	245583	B. WING	·····	04/2	04/20/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	·		
AUBURN HOME IN WACONIA			594 CHERRY DRIVE			
AUBURN HOME IN WACONIA			WACONIA, MN 55387			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG			(X5) COMPLETION DATE	
the lift was used to transpathroom. She stated this procedure in the facilty. During an interview on 4/registered nurse (RN-A) the standing lift being use the bathroom and knew of standing lift transfers and incidents related to use of RN-A stated was not away approval of the standing. The representative for the was interviewed on 4/19/representative stated the recommendations indicated designed for transferring for long distances. He stawas safe would be determed to the standing with obstruction furniture, and over multiple would also be a factor in stated the base legs shoposition when the resident may be difficult through a Physical therapist (PT)-A 4/19/17, at 2:00 p.m., and R36 recently to increase she would do an initial as	nce a long time ago," and port to R36 to the s was standard operating /19/17, at 10:30 a.m., stated she was aware of ed to transport R36 to of no problems with d stated there were no of the lift in the past year. are of an assessment for lift for R36. e standing lift provider /17, at 1:00 p.m. The manufacturer's ted the lifts were only, not for transporting ated the distance that mined by the individual de stated that tions such as turns, ole flooring surfaces determining risk. He uld remain in the wide in tis up in the lift which a doorway. A was interviewed on d stated she had seen leg strength. She stated seessment for residents would reassess if asked. of recall an assessment ng lift but stated he had	F3	are all implicated as accept the standing lift. These exa appropriate use of the lift ar with what the what the lift w for on 4/19/17. The resident had a compre assessment on 11/7/16 con RAI process. Quarterly ass were completed on 1/30/17 4/24/17. During these asse was collected pertaining to functions including transport. Regarding R36 transfer staresident has been assessed therapy for appropriate lifting be used in his plan of care, appropriate documentation intervention of using the start documented in the resident. The surveyor referenced the had not defined the distanct standing lift could be used for The facility's policy is to follow manufacturer's recommence recommendations acknowless tanding lift for transfers but transports. There is no deform transports. The facility inclusives medical in determany appropriate lifting or standing individualizes the intervention the resident's needs and althan having a specific distarpolicy.	amples of re consistent ras being used hensive inpliant with the sessments and again on essments, data all ADL relation. Itus, the idea by physical requipment to the supporting the anding lift was rescare plan, at the facility e that the for transport, ow the dations. Those redge using the it not long inition of long udes MDS and ining the reg device and on based upon billities rather		

PRINTED: 05/26/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245583	B. WING			04/2	20/2017
	PROVIDER OR SUPPLIER I HOME IN WACONIA			59	TREET ADDRESS, CITY, STATE, ZIP CODE 94 CHERRY DRIVE /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	During interview on DON stated the fact distance that the statransport. At 4:30 p not able to locate at to use the standing. The manufacturer's standing lift "Volaro 5/25/2011, directed for transferring only distances. Because designed as an assadvanced motor sk lift. It is important to appropriateness of patient." The facility policy tit Policy dated Februa mechanical stand a residents assessed	4/19/17, at 3:20 p.m., the ility had not defined the anding lift could be used for m., the DON stated she was a assessment for R36's ability lift. recommendations for the PA600/PA600S" dated that "Volaro lifts are designed that "Volaro lifts are designed that volaro sit to stand lift was istive device, it requires more ills than a traditional full body first determine the the piece of equipment for any led Mechanical Stand and Lift ary 2017, indicated "The nd lift should only be used for by a licensed health appropriate for use and	F3	23	Residents: 1. The facility is interdisciplinary (IDT) and licensed nursing staff habeen re-educated on the required rassessnents prior to the initiation of discontinuation of mechanical standifts. 2. A policy has been implemente addresses notice of Medicare non-coverage of services documer 3. The rehabilitation services department will conduct the mechastand and lift resident assessments the IDT's referral. 4. Ongoing: Residents utilizing mechanical stands and/or lifting equipment will be reviewed quarter the IDT at the quarterly care assess to ensure that the identified assess have been completed. The outcon obtained from these reviews will be conducted as part of the facility is assurance initiative for not less that year. Data obtained from the quality assurance process will be reviewed recommendations for interventions during the quarterly quality assurance meetings.	ve esident r ds and d which station. Inical sper ly by sment, ments he data e quality n one ty d, with made,	

PRINTED: 05/16/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - NEW BLDG B. WING 04/19/2017 245583 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **594 CHERRY DRIVE** AUBURN HOME IN WACONIA WACONIA, MN 55387 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

Facility ID: 00053

PRINTED: 05/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG (X3) DATE SI COMPLE				
		245583	B. WING _		04/19/2017	
	PROVIDER OR SUPPLIER HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficie 2. The actual, or pro 3. The name and/or responsible for correvent a reoccurre Auburn Home in Wa 2007, is one-story in fully fire sprinkler pro to be of Type V(111) The facility has a fir detection in the corrections, which is repartment notifical	tate.mn.us and n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. poposed, completion date. r title of the person ection and monitoring to ence of the deficiency. aconia was constructed in height, has no basement, is rotected, and was determined	K 00			
K 341 SS=C	NOT MET as evide NFPA 101 Fire Alar Fire Alarm System A fire alarm system	m System - Installation	K 3.	41		5/30/17

PRINTED: 05/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	DITIPLE CONSTRUCTION DING 02 - NEW BLDG		COMPLETED	
		245583	B. WING		04/19/2017	
	PROVIDER OR SUPPLIENT HOME IN WACONI		(STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 341	and NFPA 72, Na provide effective whilding. In areas detection is install unit. In new occupat notification appeand supervising signary fire alarm system paths are monitor 18.3.4.1, 19.3.4.1 This STANDARD Based on observing facility failed to inaccordance with I (2012) section 19 National Fire Alar This deficient practice alarm system during a fire even staff. Findings include: On the facility tou on 04/19/2017 obrevealed 3 smoke HVAC diffuser in the signary are staff.	NFPA 70, National Electric Code, tional Fire Alarm Code to warning of fire in any part of the not continuously occupied, led at each fire alarm control pancy, detection is also installed liance circuit power extenders, tation transmitting equipment. In wiring or other transmission red for integrity. 1, 9.6, 9.6.1.8 Is not met as evidenced by: ations and staff interview the stall the smoke detection in NFPA 101 Life Safety Code 1.3.4.1, 9.6.1.3 and NFPA 72 1.3.4.1, 9.6.1.3 and NFPA 72 2.5.5 m Code (2010) section 17.7.4.1 2.6.6 could affect the ability of to sound in a timely manner to which could affect all kitchen 3.4.1 m Safety Code and to sound in a timely manner to sound in a timely manner to sound in a timely manner to sound affect all kitchen and the kitchen. 3.4.1 m Safety Code and to 11:30 am servations and staff interview and electrors with 36 inches of an the kitchen.	K 341	It is the intention of Auburn Home i Waconia to be in full compliance wi applicable NFPA Life Safety Code Standards. Two of the three smoke detectors heen relocated so that they are not 36 inches of the HVAC diffuser. The smoke detector requires an electric move it. All three smoke detectors will be relocated so that they are not 36 inches of the HVAC diffuser by the date certain for this deficiency. In order to maintain compliance, the safety committee will conduct bi-antifacility risk management audits to ecompliance with all applicable NFP. Safety Code Standards. Findings we reported to the QA Committee and reviewed at the committee's quarter meeting for analysis and	nave within ne third sian to cited of within the e nual ensure A Life will be	

PRINTED: 05/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG		(X3) DATE SURVEY COMPLETED		
		245583	B. WING		04/19/2017		
	NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387			
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				



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 <u>only a suggestion</u> 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

Auburn Home In Waconia May 18, 2017 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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

PRINTED: 05/26/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00053 04/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **594 CHERRY DRIVE AUBURN HOME IN WACONIA** WACONIA, MN 55387 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/11/17

STATE FORM If continuation sheet 1 of 23 HZYK11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00053	B. WING		04/2	20/2017
	PROVIDER OR SUPPLIER N HOME IN WACONIA	594 CHER	DRESS, CITY, S RRY DRIVE A, MN 55387	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Heal you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's sand the following corplease indicate in y correction that you and identify the date Minnesota Department's the State Licensing federal software. The assigned to Minnesota Department's sand identify the date Minnesota Department's sand identify the date Minnesota Department the State Licensing federal software. The assigned to Minnesota Department is saigned to Minnesota Department in the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of co"Summary Statement and replaces the "Treorrection order. The findings which are in after the statement, evidence by." Followare the Suggested IT Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the ent of Health. and 20, 2017, surveyors of taff, visited the above provider orrection orders are issued. Our electronic plan of have reviewed these orders, ewhen they will be completed. The ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes	2 000			

Minnesota Department of Health

STATE FORM 6899 HZYK11 If continuation sheet 2 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00053	B. WING	B. WING		04/20/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
AUBURN	HOME IN WACONIA		RY DRIVE ., MN 55387				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From page 2		2 000				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency		2 545			5/30/17	
	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.			N/A			
	Findings include:						
	(MDS) dated 11/20/cognitively impaired of two staff to transhad balance that was to stabilize without a Assessment (CAA) indicated R36 had distanding position are during transitions. To dated 11/10/16, indicated endurant	ange Minimum Data Set (16, indicated he was severely and required extensive assist fer. The MDS indicated R36 as unsteady and was unable assistance. A Care Area for falls dated 11/10/16, difficulty maintaining and had impaired balance he CAA for functional status acated R36 had weakness, ce and hemiparesis side of the body) that could					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00053	B. WING		04/2	0/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
AUBUR	N HOME IN WACONIA		RY DRIVE A, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 545	Continued From pa	ge 3	2 545			
	assist to transfer us plan did not address R36 from the bed to During observation was transferred from standing lift. Nursing the lift and the direct to R36. R36 had as knees were bent and sling instead of standing instead of standing instead of standing instead of the alcove, and into the transport of approxiculation over carpeted floor, onto the bathroom onto the toilet then wheelchair positions stated at the time of use the standing lift to the bathroom with the bathroom. She state procedure in the fact During an interview registered nurse (R the standing lift transfer incidents related to	on 4/19/17, at 7:50 a.m., R36 in the bed to the bathroom in a grassistant (NA)-B operated ator of nursing (DON) was next sling around his back, his ad he was leaning back on the ading upright. R36 was pushed the bed, into the entrance bathroom during the mately 20 feet. The lift went over a plastic threshold, and alloring. R36 was lowered transferred from the toilet to a to the transfer it was usual to to transport R36 from the bed in assist of 2 staff. The don 4/19/17, at 9:10 a.m., dard way to transfer R36 was iff "since a long time ago," and transport to R36 to the ted this was standard operating silty. On 4/19/17, at 10:30 a.m., N-A) stated she was aware of the used to transport R36 to the sed the transport R36 to the ted the transport R36 to the ted this was standard operating silty.				

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00053	B. WING		04/2	20/2017
	PROVIDER OR SUPPLIER N HOME IN WACONIA	594 CHEF	DRESS, CITY, S RRY DRIVE A, MN 55387	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 545	The representative was interviewed on representative state recommendations in designed for transfer for long distances. It was safe would be resident's assessme transporting with obtaining and over a would also be a fact stated the base legates position when the remay be difficult through the following a standing lift PT-A stated she confor R36 to use the standing and in the state of the fact distance that the state of the standing lift "Volaro 5/25/2011, directed for transferring only distances. Because designed as an assistance of the standing lift and standing lift grant only distances. Because designed as an assistance of the standing lift grant only distances. Because designed as an assistance in the standing lift grant only distances. Because designed as an assistance in the standing lift grant only distances. Because designed as an assistance in the standing lift grant only distances. Because designed as an assistance in the standing lift grant of the standing lift grant only distances. Because designed as an assistance in the standing lift grant of t	for the standing lift provider 4/19/17, at 1:00 p.m. The ed the manufacturer's indicated the lifts were erring only, not for transporting. He stated the distance that determined by the individual ent. He stated that instructions such as turns, multiple flooring surfaces for in determining risk. He is should remain in the wide esident is up in the lift which hugh a doorway. PT)-A was interviewed on in., and stated she had seen ease leg strength. She stated tial assessment for residents, and would reassess if asked. In all the earling lift but stated he had the earling lift but stated he had the earling lift could be used for in., the DON stated she was in assessment for R36's ability lift. The recommendations for the PA600/PA600S" dated that "Volaro lifts are designed to the volaro sit to stand lift was istive device, it requires more ills than a traditional full body	2 545			

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STATE FORM 6899 HZYK11 If continuation sheet 5 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	20/2017
					1 04/2	.0/2017
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 545	Continued From pa	ge 5	2 545			
	appropriateness of patient."	the piece of equipment for any				
	Policy dated Februa mechanical stand a residents assessed	led Mechanical Stand and Lift ary 2017, indicated "The nd lift should only be used for by a licensed health appropriate for use and dent record."				
	The director of nurs review and revise p to ensuring assess appropriate for char of nursing or design educate staff and de	HOD OF CORRECTION: sing (DON) or designee could olicies and procedures related ments are conducted as nges in condition. The director nee could develop a system to evelop a monitoring system to viding care as directed by the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			5/30/17
		omprehensive plan of care personnel involved in the .				
	by: Based on observatireview the facility fadirected by the plan	ent is not met as evidenced on, interview and document illed to provide services as of care for repositioning and check and change program)		N/A		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	<u> </u>	
AUBURN	I HOME IN WACONIA		RY DRIVE ., MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 6		2 565			
	for 1 of 2 residents (R45) reviewed for positioning and activities of daily living (ADL's.)					
	Findings include:					
	(MDS) dated 3/27/1 cognitively impaired ADL's and was alw bladder. An Auburn Assessment dated unable to recognize toilet and was on a R45's care plan dat to assist with toiletin R45 was on a Dignichecking and changmanagement.) The	nange Minimum Data Set 7, indicated she was severely d, dependent on staff for all vays incontinent of bowel and Home Waconia Bladder 3/24/17, indicated R45 was and respond to signals to scheduled toileting program. Led 4/7/17, directed facility staffing. The care plan indicated ity Care Program (routine ging for incontinence care plan did not identify a neck and change program.				
		ation on 4/19/17, from 7:00 identified the following:				
	Broda chair (a spector prevent skin breaks) of the neighborhood legs and her eyes wat 7:25 a.m., R45 rechair. Trained mediapproached R45 arfrom a spoon, assis walked away. R45 hindependent mover remained seated in hands were on her made repetitive sout to move both of her kneading type of mediapproached seated in hands were on her made repetitive sout of the kneading type of mediapproached seated in hands were on her made repetitive sout of move both of her kneading type of mediapproached seated in hands were on her made repetitive sout of the kneading type of mediapproached seated seated in hands were on her kneading type of mediapproached seated seat	emained seated in the Broda cation aide (TMA)-A and administered medications sted R45 to drink water and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00053	B. WING		04/2	20/2017
	PROVIDER OR SUPPLIER	594 CHEF	DRESS, CITY, S RRY DRIVE A, MN 55387	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	the Broda chair. Re approached R45 ar room table. RN-C s breakfast. At 8:20 a the Broda chair at the a.m., she finished he R45 back to the family received the television. At 9: approached R45 ar activity. The activity chapel for newspap remained until 10:0 back to the family received to the R45's moderately the family received to the	gistered nurse (RN)-C nd wheeled her to a dining at next to R45 and fed her a.m., R45 remained seated in the dining room table. At 8:59 ther breakfast. RN-C wheeled nily room and put her next to 11 a.m., the activities director and offered to assist her to an a director escorted R45 to the there reading where she 6 a.m. R45 was then escorted boom. where she remained which time RN-B was notified in a seated position without tance with cares for 3 hours N-B confirmed R45 required the all cares which included	2 565			
		ere to anticipate her needs.				

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Minnesota Department of Health

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED
		00053	B. WING	·····	04/	20/2017
	PROVIDER OR SUPPLIER N HOME IN WACONIA	594 CHEF	DRESS, CITY, S RRY DRIVE A, MN 55387	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	changing program incontinence. RN-B breakdown and was history of skin breal perineal area. RN-E when R45 had gotte R45 should have be 2 hours. During an interview NA-A stated she had the Broda chair from morning. NA-A statestaff for all cares are anticipated by staff. every 2 hour routing for incontinence and During an interview RN-A confirmed R45 was on a Dignincluded a routine of program for incontinence program for incontinence brief at turn and reposition she would expect for incontinence brief at During an interview TMA-A stated R45 needs and required checking and changed bladder assessment for residents and be a changed bladder assessment for residents and bladder assessment for residents a	to manage urinary stated R45 at risk for skin is unaware if R45 had any kdown of her buttocks or is stated she was unsure of en up for the day and stated een repositioned at least every on 4/19/17, at 10:45 a.m., id thought R45 had been up in mapproximately 6:45 a.m. that ed R45 was dependent on ind R45's needs were to be NA-A stated R45 was on a e check and change program	2 565			

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	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	20/2017	
	PROVIDER OR SUPPLIER N HOME IN WACONIA	594 CHER	DRESS, CITY, S RRY DRIVE A, MN 55387	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 565	incontinence. She standard of practice reposition residents breakdown. The DC Care was in place f she would expect a R45 to be checked She further stated t specific policy and presidents care plan expectation all staff. SUGGESTED METHE The director of nurs review and revise p to ensuring the care resident is followed designee could devand develop a mon are providing care a of care.	stated it was the facility's to routinely turn and severy 2 hours to prevent skin DN further stated if Dignity or a resident, such as R45, to the time of repositioning, and changed for incontinence. The facility did not have a procedure for following a and indicated it was an	2 565				
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			5/30/17	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED
		00053	B. WING		04/2	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUBURN	I HOME IN WACONIA		RRY DRIVE A, MN 55387	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	This MN Requirements: Based on observation review the facility factorial assess 1 of 2 resident transfers, for safe of transfers, for safe of transfers, for safe of the significant changes of two staff to transhad balance that we to stabilize without a Assessment (CAA) indicated R36 had of standing position and during transitions. Tone fall with injury some fall without	ent is not met as evidenced on, interview, and document ailed to comprehensively ents (R36) observed for use of the standing lift. ange Minimum Data Set (16, indicated he was severely and required extensive assist fer. The MDS indicated R36 as unsteady and was unable assistance. A Care Area for falls dated 11/10/16, difficulty maintaining and had impaired balance. The CAA indicated R36 had since the last assessment. In al status dated 11/10/16, weakness, decreased air could effect transfers. ed 6/21/12, indicated two staffers ing a sit to stand lift. The care is the use of the lift to transport of the bathroom. on 4/19/17, at 7:50 a.m., R36 m the bed to the bathroom in a g assistant (NA)-B operated		N/A		
	the lift and the director R36. R36 had a	etor of nursing (DON) was next sling around his back, his and he was leaning back on the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00053	B. WING		04/2	20/2017
	NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA STREET A 594 CHE WACONI			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	sling instead of star around the end of the alcove, and into the transport of approxice over carpeted floor, onto the bathroom onto the toilet then wheelchair positions stated at the time of use the standing lift to the bathroom with the lift was interviewed and stated the standing lift was used to bathroom. She state procedure in the fact that bathroom and keep standing lift transfer incidents related to RN-A stated was not approval of the standing lift being the bathroom and keep standing lift transfer incidents related to RN-A stated was not approval of the standing lift being the bathroom and keep standing lift transfer incidents related to RN-A stated was not approval of the standing lift transfer incidents related to RN-A stated was not approval of the standing lift being the standing lift transfer incidents related to RN-A stated was not approval of the standing lift being the standing lift being the standing lift being the standing lift transfer incidents related to RN-A stated was not approval of the standing lift being the standing lift	nding upright. R36 was pushed the bed, into the entrance to bathroom during the smately 20 feet. The lift went over a plastic threshold, and flooring. R36 was lowered transferred from the toilet to a ted in the bathroom. The DON of the transfer it was usual to to transport R36 from the bed the assist of 2 staff. The don 4/19/17, at 9:10 a.m., dard way to transfer R36 was ift "since a long time ago," and transport to R36 to the ted this was standard operating cilty. The don 4/19/17, at 10:30 a.m., N-A) stated she was aware of the used to transport R36 to the ted this was attended to the post year. The transfer R36. The standing lift provider and the standing lift provider and the manufacturer's the manufacturer's the dicated the lifts were the tring only, not for transporting the stated the distance that determined by the individual	2 830			

Minnesota Department of Health

STATE FORM 6899 HZYK11 If continuation sheet 12 of 23

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COM			SURVEY LETED
		00053	B. WING		04/2	0/2017
	PROVIDER OR SUPPLIER	594 CHER	DRESS, CITY, S RRY DRIVE 1, MN 55387	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	position when the remay be difficult thrown and be difficult thrown as the difficult thrown as the would do an initial using a standing lift PT-A stated she confor R36 to use the sused it for a long timentioned in team. During interview on DON stated the fact distance that the statransport. At 4:30 p not able to locate at the statransport of the standing lift "Volaro 5/25/2011, directed for transferring only distances. Because designed as an assadvanced motor skilft. It is important to appropriateness of patient." The facility policy tit Policy dated Februar mechanical stand a residents assessed professional to be a identified in the residual standares. Suggested that the standares assessed professional to be a identified in the residual standares.	esident is up in the lift which hugh a doorway. PT)-A was interviewed on n., and stated she had seen ease leg strength. She stated tial assessment for residents, and would reassess if asked. In the interviewed in a sessment standing lift but stated he had ne and no issues had been meetings. 4/19/17, at 3:20 p.m., the illity had not defined the anding lift could be used for lim., the DON stated she was not assessment for R36's ability lift. The recommendations for the PA600/PA600S" dated that "Volaro lifts are designed to the volaro sit to stand lift was istive device, it requires more ills than a traditional full body of first determine the the piece of equipment for any led Mechanical Stand and Lift ary 2017, indicated "The not lift should only be used for by a licensed health appropriate for use and	2 830			

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ATE FORM HZYK11 If continuation sheet 13 of 23

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
AUBURN	I HOME IN WACONIA		RRY DRIVE A, MN 55387	,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830 2 905	care and treatment, and supervision bas preferences as ider resident assessmer designee could provstaff education regresident records for TIME PERIOD FOF (21) days. MN Rule 4658.0525	re residents receive nursing personal and custodial care, sed on individual needs and ntified in the comprehensive nt. The director of nursing or vide review policies, provide arding polices, and audit compliance. R CORRECTION: Twenty-one 5 Subp. 4 Rehab - Positioning	2 830			5/30/17	
	positioned in good to fresidents unable must be changed a including periods of been put to bed for has documented the hours during this tin the physician has of	g. Residents must be body alignment. The position to change their own position t least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or redered a different interval.					
	Based on observation review the facility farepositioning for 1 of for positioning and inbreakdown. Findings include: R45's significant change (MDS) dated 3/2 severe cognitive im	on, interview and document illed to ensure timely of 1 residents (R45) reviewed identified at risk for skin nange of status Minimum Data 27/17, indicated she had pairment related to dementia. she was totally dependent on		N/A			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	20/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ALIBURN HOME IN WACONIA		RRY DRIVE A, MN 55387				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	facility staff for all a and identified a risk development. Revir Predicting Pressure indicated R45 was based on moisture nutrition, friction an Tolerance Assessmant for skin breakd identified R45 was maintain healthy sk repositioning every Broda chair. Review of R45's Cadated 3/27/17, indice verbally communicate dependent on facility staff to anticipate h R45 was at high risk history of moisture (MASD) and had lisk were in place to preincluded; facility state two hours, pressure protein to her diet. R45's care plan daskin breakdown relembility, cognitive of care plan directed in reposition every 2 h Broda wheelchair to the neighborhoolegs and her eyes were said to the neighborhoolegs and her eyes were released to the neighborhoolegs and her eyes were resulted.	activities of daily living (ADL's) a for pressure ulcer ew of a Braden Scale for e Ulcer Risk, dated 3/24/17, at high risk for skin breakdown, decreased mobility, activity, d shear. Review of a Tissue nent (a tool used to assess lown,) dated 3/24/17, required interventions to kin which included; turning and 2 hours and a cushion in the lare Area Assessment (CAA) cated she was unable to late her needs, was totally the staff for ADL's and directed er needs. The CAA revealed like for skin breakdown, had a lassociated skin damage sted various interventions that levent skin breakdown which laff assist to reposition every er relieving surfaces and added lated 4/7/17, identified a risk for lated 4/7/17, identifi	2 905			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I AUBURN HOME IN WACONIA			RY DRIVE 1, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	chair. Trained mediapproached R45 ar from a spoon, assis walked away. R45 hindependent mover remained seated in hands were on her made repetitive souto move both of her kneading type of molower body. At 8:09 the Broda chair. Reapproached R45 ar room table. RN-C subreakfast. At 8:20 at the Broda chair at the armonauth. Should be a should be	cation aide (TMA)-A nd administered medications sted R45 to drink water and had not made any ments. At 7:35 a.m., R45 the Broda chair, both of her blanket covered lap and R45 inds of humming and began hands in a repetitive otion. R45 did not move her a.m., R45 remained seated in gistered nurse (RN)-C nd wheeled her to a dining at next to R45 and fed her a.m., R45 remained seated in he dining room table. At 8:59 her breakfast. RN-C wheeled nily room and put her next to 11 a.m., the activities director and offered to assist her to an director escorted R45 to the her reading where she 6 a.m. R45 was then escorted bom. where she remained which time RN-B was notified in a seated position without tance with cares for 3 hours lance with cares lance with care lance with ca	2 905			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING O4/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WACONIA, MN 55387 (X5)		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA STREET ADDRESS, CITY, STATE, ZIP CODE WACONIA, MN 55387 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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							
AUBURN HOME IN WACONIA Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			00053	B. WING		04/2	20/2017
AUBURN HOME IN WACONIA (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 a risk for skin breakdown and was unaware if R45 had any history of skin breakdown of her buttocks or perineal area. RN-B	NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 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	AUBURI	N HOME IN WACONIA			,		
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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 facility 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	2 905	During an interview RN-C stated R45 w staff for her ADL's, in her position to pr stated R45 was no needs and she felt R45's needs. During an interview RN-B stated R45 w needs, and staff we RN-B stated R45 w and was unaware it breakdown of her b stated she was unsremained seated in R45 should have be 2 hours. During an interview NA-A stated she hat the Broda chair from morning. NA-A stated she hat the Broda chair from morning. NA-A stated she hat staff for all cares are anticipated by staff why R45 was not results. RN-A confirmed R45 breakdown based or results.	on 4/19/17, at 10:27 a.m. vas totally dependent on facility and required routine changes event skin breakdown. She longer able to verbalize her staff needed to anticipate on 4/19/17, at 10:37 a.m. vas not able to verbalize her ere to anticipate her needs. vas at risk for skin breakdown f R45 had any history of skin buttocks or perineal area. RN-B sure of how long R45 had the Broda chair and stated een repositioned at least every on 4/19/17, at 10:45 a.m. that ed R45 was dependent on a proximately 6:45 a.m. that ed R45 was dependent on and R45's needs were to be. NA-A stated she was unsure epositioned timely. on 4/19/17, at 12:59 p.m. Is was at risk for skin on TTT and Braden scale rmed R45's care plan directed and reposition every 2 hours. also the facility's standard at risk residents every 2	2 905			

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-	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00053	B. WING		04/2	0/2017
	NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA 594 CH WACON			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905	day to a TMA due to TMA-A stated she with other NA when a needed to be repositions was unable to verba assistance with rour hours. During an interview director of nursing (as R45, risk for skir using a TTT and Br based on the assest planned with intervestance with intervestance with preakdown. The facility's standard of reposition residents breakdown. The DC expect facility staff risk for skin breakdown. The DC expect facility staff risk for skin breakdown repositioned every at the first for skin breakdown. The DC expect facility staff risk for skin breakdown at the control of the co	o a staff member calling in ill. would usually verbally report to a resident, such as R45, itioned. TMA-A stated R45 alized her needs and required tine repositioning every 2 on 4/19/17, at 2:15 p.m. the DON) stated residents, such a breakdown was assessed aden scale. The DON stated isments, residents were care entions to reduce the risk for the DON stated it was the for practice to routinely turn and severy 2 hours to prevent skin DN further stated she would to ensure R45, who was at own, would be turned and 2 hours. Policy titled, Repositioning, cated it was the facility's policy are plans for repositioning. THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure necessary treatment/services, go to prevent pressure ulcers the director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 905			

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00053	B. WING		04/2	20/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S RRY DRIVE	STATE, ZIP CODE		
ALIBURN HOME IN WACONIA			N, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 18	2 910			
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			5/30/17
	have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident whreceives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ig catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to infections and to restore as er function as possible.				
	by: Based on observative review the facility facility facility facility facility facility facility facility facility facility.	ent is not met as evidenced on, interview and document alled to provide a timely check m for urinary incontinence of 2 residents (R45) reviewed v living (ADL's.)		N/A		
	Findings include:					
	(MDS) dated 3/27/1 cognitively impaired ADL's and was alw bladder. Review of (CAA) dated 3/27/1 dependent on facilities.	nange Minimum Data Set 17, indicated she was severely d, dependent on staff for all vays incontinent of bowel and R45's Care Area Assessment 7, indicated she was totally ty staff for ADL's, including hal hygiene and indicated she				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	00053	B. WING		04/2	0/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
AUBURN HOME IN WACONIA		RRY DRIVE				
7.020	WACONIA	, MN 55387				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
no longer used the Waconia Bladder A indicated R45 was respond to signals to scheduled toileting dated 4/7/17, direct toileting. The care polignity Care Prograchanging for incontinuous observation a.m. to 10:32 a.m., At 7:00 a.m., R45 was Broda chair (a spector of the neighborhood legs and her eyes worder a.m., R45 rechair. Trained mediapproached R45 art from a spoon, assist walked away. R45 hindependent mover remained seated in hands were on her made repetitive sout to move both of her kneading type of molower body. At 8:09 the Broda chair. Reapproached R45 art room table. RN-C storeakfast. At 8:20 at the Broda chair at the a.m., she finished her R45 back to the familiar since the single shock to the familiar to single sho	nent of bowel and bladder and toilet. An Auburn Home ssessment dated 3/24/17, unable to recognize and to toilet and was on a program. R45's care plan ed facility staff to assist with plan indicated R45 was on a am (routine checking and inence management.) ation on 4/19/17, from 7:00 identified the following: vas seated in a cushioned cial wheelchair used to help down) in the family room area d unit, a blanket covered her were closed. emained seated in the Broda cation aide (TMA)-A and administered medications sted R45 to drink water and	2 910				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00053	B. WING		04/2	0/2017	
	PROVIDER OR SUPPLIER N HOME IN WACONIA	594 CHER	DDRESS, CITY, STATE, ZIP CODE RRY DRIVE A, MN 55387				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 910	activity. The activity chapel for newspap remained until 10:0 back to the family runtil 10:24 a.m., at R45 had remained being offered assis and 24 minutes. Ristaff assistance wit routine repositionin. At 10:27 a.m., RN-escorted her to the R45's moderately and lowered her to large amount of urinand nursing assista bathroom, at that til R45 off the toilet ar During interview on stated R45 was totafor all ADL's and waknow of her needs, stated R45 required changing to manag During an interview RN-B stated R45 when R45 was totafor all ADL's and waknow of her needs, stated R45 required changing to manag During an interview RN-B stated R45 when R45 was totaff we RN-B stated R45 when R45 when R45 had gotten R4	r director escorted R45 to the per reading where she 6 a.m. R45 was then escorted from. Where she remained which time RN-B was notified in a seated position without tance with cares for 3 hours N-B confirmed R45 required in all cares which included go fevery 2 hours. C approached R45 and bathroom. RN-B removed wrine soiled incontinent brief the toilet where she voided a me. RN-A then left the room, ant (NA)-A entered R45's me RN-C and NA-A assisted and back into her Broda chair. 4/19/17, at 10:27 a.m., RN-C ally dependent on facility staff including toileting. RN-C devery 2 hour checking and e urinary incontinence. on 4/19/17, at 10:37 a.m. as not able to verbalize her the reet of an an an aroutine check and	2 910				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00053	B. WING		04/2	20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
AUBURN HOME IN WACONIA 594 CHERRY DRIVE WACONIA, MN 55387							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 910	During an interview NA-A stated she had the Broda chair from morning. NA-A stated staff for all cares are anticipated by staff. every 2 hour routin for incontinence and During an interview RN-A confirmed R4 bowel and bladder facility staff for toile R45 was on a Dignincluded a routine or program for incontine confirmed R45's caturn and reposition she would expect faincontinence brief at During an interview TMA-A stated she had at approxim R45 was unable to required assistance and changing with rector of nursing (bladder assessment for residents and bainterventions were princontinence. She standard of practice reposition residents breakdown. The DC Care was in place of she would expect as	on 4/19/17, at 10:45 a.m., ad thought R45 had been up in approximately 6:45 a.m. that ed R45 was dependent on a R45's needs were to be NA-A stated R45 was on a le check and change program d repositioning. on 4/19/17, at 12:59 p.m., so was incontinent of both and was totally dependent on ting and hygiene. RN-A stated ity Care program which checking and changing nence management. RN-A are plan directed facilty staff to every 2 hours and at that time acility staff to check R45's and change as needed. on 4/19/17, at 1:35 p.m., and assisted R45 to get up for nately 6:45 a.m. TMA-A stated werbalized her needs and with every 2 hour checking	2 910				

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0053

| Multiple Construction | (X2) Multiple Construction | (X3) DATE SURVEY | (X3) DATE SURVEY | (X4) Multiple Construction | (X5) DATE SURVEY | (X6) DATE SURVEY | (X7) DATE S

					, _ 0, _ 0	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I ALIBURN HOME IN WACONIA			RRY DRIVE			
AUDUNIN	THOME IN WACCINIA	WACONIA	, MN 55387			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (EACH DEFICIENCY MUST BE PRECEI REGULATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 910	Continued From page 22		2 910			
	The DON stated the facility did not or procedure which addressed Dig checking and changing program for	gnity Care or				
	SUGGESTED METHOD OF COR The director of nursing or designe all residents at risk for urinary inco assure they are receiving the nece treatment/services to prevent urina infections and to restore as much function as possible.pressure ulce developing and to promote healing ulcers. The director of nursing or conduct random audits of the deli ensure appropriate care and servicimplemented. TIME PERIOD FOR CORRECTION (21) days	e, could review ontinence to essary ary tract normal bladder ers from g of pressure designee, could every of care to ces are				

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