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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L516

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00053

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/21/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5583

Electronically Delivered: September 11, 2014

Mr. Rick Krant, Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, Minnesota 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 July 23, 2014, the above facility is certified 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 29, 2014

Mr. Rick Krant, Administrator
Auburn Home in Waconia
594 Cherry Drive
Waconia, Minnesota 55387

RE: Project Number S5583022

Dear Mr. Krant:

On June 27, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 13, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 28, 2014 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 June 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 13, 2014, effective July 23, 2014 and therefore remedies outlined in our letter to you dated June 27, 2014, 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245583	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/23/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/23/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/23/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/23/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/23/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	07/29/2014	16022	07/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/13/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245583	02 - NEW BLDG	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN HOME IN WACONIA	594 CHERRY DRIVE WACONIA, MN 55387

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 07/23/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	07/29/2014	22373	07/28/2014
CMS RO				

Followup to Survey Completed on: 6/13/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L516

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245583**
2.STATE VENDOR OR MEDICAID NO.
(L2) **211027000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Shawn M. Soucek, HPR SW Specialist 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/21/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5163

June 27, 2014

Mr. Rick Krant, Administrator
Auburn Home in Waconia
594 Cherry Drive
Waconia, Minnesota 55387

RE: Project Number S5583022

Dear Mr. Krant:

On June 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 23, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 23, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the

State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 13, 2014 (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 December 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	06/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	(See Attached)	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 2 of 3 residents (R18, R60) reviewed for accidents. Findings include: R18's care plan dated 6/1/14, identified R18 as at risk for falling, and directed staff to keep the bed in lowest position with brakes locked. On 6/12/14, at 9:28 a.m., R18 was observed to transfer from the wheelchair into bed with assistance of nursing assistant (NA)-C. R18 did not have a low bed.	F 282	POC accepted as Plan tho 7/11/14 RECEIVED JUL 11 2014	

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

Administrator — 7/11/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING _____ B. WING _____	06/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 When interviewed, NA-C stated R18 does not have a low bed. On 6/11/14, at 1:26 p.m. the DON and registered nurse (RN)-A were interviewed and stated the nursing assistants had worksheets to direct them on fall interventions. Review of the nursing assistant worksheet, undated, did not direct staff to keep the bed in a low position. R60's care plan dated 5/1/14, indicated R60 was at risk for falling, and directed staff to keep the bed in the lowest position, and use alarms. The nursing assistant worksheet undated, directed bed in low position, and alarms when R60 was in the wheelchair and in the bed. On 6/12/14, at 9:09 a.m. R60 was observed to transfer from the wheelchair into a low bed with assistance of nursing assistant (NA)-C. There was no alarm on the wheelchair or the bed. Interview with, NA-C regarding the alarms for the wheelchair and bed, NA-C stated R60 did not have alarms and thought they had been discontinued. NA-C went to the desk to check on the alarms and stated R60 should have alarms on in the wheelchair and when in bed, and would go get the alarms.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify causal factors of falls, failed to determine if appropriate interventions and measures were implemented to minimize the risk of falls, and/or failed to assure that care plans were followed and interventions were communicated consistently to staff for 3 of 3 residents (R84, R18, R60) reviewed for accidents. Findings include: R84's admission record identified diagnoses that included history of fall with fracture of the femur. The admission MDS dated 4/2/14, indicated R84 was severely cognitively impaired and required extensive assistance of one staff with transfers, bed mobility, dressing, toileting, personal hygiene and bathing. The MDS further identified R84 had a fall in the month prior to admission, and sustained a fracture related to a fall in the past six months prior to admission. The CAA initiated 4/7/14, unsigned and not dated as completed, indicated R84 was at risk for falls, had a history of falls, and recently fell at home and sustained a hip fracture. The care plan dated 3/26/14, indentified R84 had a history of frequent falls, and was on an ambulation and toileting program. The nursing assistant worksheet, undated, directed the following interventions: mat on floor, bed and wheelchair alarms, and bed in low position.	F 323		

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F 323	Continued From page 3 The fall risk assessment completed 4/7/14, indicated R84 was at high risk for falls, no referrals were needed, and to continue with current plan of care. Review of event reports and progress notes identified R84 sustained the following falls: On 4/4/14, at 5:25 p.m. R84 was found on the floor in the room in front of recliner. Resident stated he was reaching for something and doesn't know what happened. No obvious injuries. A tab alarm was initiated in the bed and chairs. On 5/19/14, at 4:58 a.m. R84 was found on the floor in the day room. Was sitting in w/c and attempted to self transfer, setting Tabs Alarm off. No apparent injuries. On 5/20/14, at 11:42 p.m. R84 was found on the floor next to the bed. Measures taken: Bed alarm. On 6/2/14, at 3:50 p.m. R84 fell out of wheelchair in the dayroom. R82 sustained a skin tear to the left index finger. On 6/6/14, at 4:11 p.m. R84 was watching TV and slid out of wheelchair in the dayroom. No injuries noted. On 6/10/14, at 11:35 p.m. resident crawled out of bed and was found with tab alarm still attached to resident and resident was lying on floor mat. No injuries. A post-fall assessment completed for this fall, at 1:24 p.m., identified R84 had numerous falls, interventions in place included a walking and toileting program, going outdoors with staff, and	F 323		

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F 323	Continued From page 4 physical therapy assessment. On 6/12/14, at 9:20 a.m. trained medication aide (TMA)-B and NA-C were observed transferring R84 from the wheelchair to the recliner. R84 had a tabs alarm on the wheelchair, and NA-C placed it on the recliner. Although interventions of tab alarms, low bed and mat had been implemented, there was no analysis after the falls to determine what the resident's needs may have been before the fall. There was no documentation to indicate that the current interventions had been assessed to determine if they were appropriate or if alternative interventions had been discussed. On 6/11/14, at 9:56 a.m., the director of nursing (DON) was interviewed and stated the facility does not always complete a specific post fall reassessment form; at times a post fall assessment may be a progress note, or on the fall event form. The DON further stated all falls were reviewed weekly in a team meeting. On 6/11/14, at 1:26 p.m. the DON and registered nurse (RN)- A were interviewed and stated the nursing assistants had worksheets to direct them on fall interventions. Both the DON and RN-A stated the facility completes a fall review weekly at the interdisciplinary meeting (IDT), but stated they do not document what was discussed. R18 resided in the facility over 4 years. R18's care plan identified diagnoses that included Parkinson's disease, macular degeneration and dementia. The quarterly Minimum Data Set (MDS) dated 3/5/13, indicated R18 was	F 323		

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F 323	Continued From page 5 cognitively intact, and required extensive assistance of one staff for bed mobility, ambulation, toileting, personal hygiene and eating. The MDS further identified R18 required extensive assistance of two staff for transfers, and total assistance of one staff for wheelchair mobility, dressing and bathing. The MDS indicated R18 was occasionally incontinent of bowel and bladder, and had one fall since the prior assessment. The Care Area Assessment (CAA) initiated 5/30/14, unsigned and not dated as completed, indicated R18 was at high risk for falls, required assistance of one to two staff with transfers and bed mobility, had impaired balance when standing, and did not attempt to self-ambulate. R18 sustained the following fall: On 5/10/14, at 8:27 p.m. R18 fell in the bathroom. R18 had been sitting on the toilet, and attempted to transfer unassisted off of the toilet. R18 was not injured, and required assistance of two staff to transfer off of the floor. R18's fall risk assessment was completed 5/27/14, 17 days after R18's fall. The fall risk assessment indicated R18 was at high risk for falls, but lacked interventions to be used to prevent falls, and indicated no referrals were necessary. The care plan dated 6/1/14, identified R18 as at risk for falling related to psychotropic drug use and Parkinson's disease/tremors and to give resident verbal reminders not to ambulate/transfer without assistance. The care plan also directed staff to keep the bed in lowest	F 323		

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F 323	Continued From page 6 position with brakes locked. On 6/11/14, at 1:26 p.m. the DON and registered nurse (RN)-A were interviewed regarding fall intervention communication for staff and stated the nursing assistants had worksheets to direct them on fall interventions. On 6/12/14, at 9:28 a.m. R18 was observed to transfer from the wheelchair into bed with assistance of nursing assistant (NA)-C. R18 did not have a low bed. NA-C stated R18 does not have a low bed. The care plan directed staff to keep the bed in lowest position, however, review of the nursing assistant worksheet, undated, did not direct staff to keep the bed in a low position. R60's admission MDS dated 4/3/14, indicated R60 was cognitively intact and required extensive assist of one staff with bed mobility, transfers, toileting, personal hygiene and bathing, and extensive to total assistance with wheelchair mobility. The MDS indicated R60 had not had any falls since admission. The CAA started 4/9/14, unsigned and not dated as completed, indicated R60 was at risk for falls, had poor balance related to a decline in health care, and required assistance of one to two staff with activities of daily living (ADLs). The care plan dated 5/1/14, indicated R60 was at risk for falling, and directed staff to keep the bed in the lowest position and use alarms. The nursing assistant worksheet undated, directed bed in low position, and alarms when R60 was in the wheelchair and in the bed.	F 323		

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F 323	Continued From page 7 The fall risk assessment dated 6/11/14, indicated R60 was at high risk for falls, and other interventions were in place - low bed, alarm. R60 sustained the following falls: On 6/7/14, at 11:45 a.m. R60 was found on the floor mat next to the bed. R60's bed alarm was sounding. R60 was noted to have confusion prior to and following the fall, and the physician was notified and ordered lab work to be done. On 6/7/14, at 10:15 p.m. R60 was found on the floor mat next to the bed. R60 did not have an injury. On 6/12/14, at 9:09 a.m. was observed to transfer from the wheelchair (which did not have an alarm on it) into bed with assistance of nursing assistant (NA)-C. R60 was observed to have a low bed, and when the transfer was completed and R60 was resting in bed, NA-C was questioned regarding the alarms for the wheelchair and bed. NA-C stated R60 did not have alarms, she thought they were discontinued, but indicated that she was not using the nursing assistant worksheet. NA-C then went to the desk to check on the alarms, got the nursing assistant worksheet and reported that R60 should have alarms on the wheelchair and when in bed. The facility policy and procedure for falls dated 6/14/12, directs all residents will be assessed for the potential for falls upon admission, quarterly, annually and after any fall that occurs resulting in a change in condition. Upon admission, quarterly and annually the assistant director of nursing or designee will complete the falls risk assessment,	F 323		

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F 323	Continued From page 8 if fall occurs, as soon as possible after the occurrence of the fall. All falls will be addressed at the weekly IDT meeting, or sooner if needed, to determine the appropriate interventions to reduce or prevent recurrence of falls. This intervention will be communicated to the appropriate departments. On 6/12/14, at 8:10 a.m., the DON verified that post fall risk assessment had not been completed for R84 for the first five falls, and that no post fall assessments had been completed for R18 or R60.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 9	F 329		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted for the use of Seroquel (an antipsychotic medication used to treat schizophrenia and bipolar disorder) for 1 of 5 residents (R46) reviewed for unnecessary medications.

Findings included:

R46's care plan dated 3/17/14, identified diagnoses that included sensory illusions and hallucinations related to dementia. The quarterly Minimum Data Set (MDS) dated 5/27/14, indicated R46 was cognitively intact, and had no hallucinations, delusions or behaviors exhibited.

On 4/21/13, the physician ordered Seroquel 25 milligrams (mg) twice a day for diagnosis of dementia with behavioral disturbances. The care plan directed to update the physician for consideration of medication reduction every six months and as needed. R46's medical record lacked indication of the physician update, any attempt to gradually reduce the dose of Seroquel, or any active behaviors.

On 6/12/14, at 9:41 a.m. nursing assistant (NA)-C was interviewed and stated she hasn't noticed any hallucinations or behaviors for R46.

On 6/13/14, at 7:53 a.m. registered nurse (RN)-A was interviewed and verified there had not been a

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F 329	Continued From page 10 gradual dose reduction attempted. RN-A further stated the facility should fax the physician yearly and request a GDR. The facility policy and procedure on psychotropic drug dose reduction dated 6/10, directed a psychotropic drug dose reduction attempt will be made within the first year, in two separate quarters, (with at least one month between attempts), then annually.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

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F 356	Continued From page 11 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required daily nursing staffing information included the actual hours for the day shift, evening shift and night shift. This had the potential to affect all residents residing in the facility, as well as family members or the general public. Findings include: During the initial tour on 6/9/14 at 6:30 p.m., the posting of the nurse staffing hours was located at the reception area. During observation of the nurse staff posting on 6/9/14, it was observed the posting failed to include exact hours that nursing staff worked each shift by discipline. During an interview on 9/12/14 at 11:00 a.m., the director of nursing (DON) verified the nurse staffing hours did not include specific hours worked and would make the necessary corrections to the form. No policy was provided.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 12	F 428		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the consultant pharmacist failed to recommend a gradual dose reduction (GDR) for 1 of 5 residents (R46) reviewed for unnecessary medications.

Findings included:

R46's care plan dated 3/17/14, identified diagnoses that included sensory illusions and hallucinations related to dementia. The quarterly Minimum Data Set (MDS) dated 5/27/14, indicated R46 was cognitively intact, and had no hallucinations, delusions or behaviors exhibited.

On 4/21/13, the physician ordered Seroquel 25 milligrams (mg) twice a day for diagnosis of dementia with behavioral disturbances. The care plan directed to update the physician for consideration of medication reduction every six months and as needed. R46's medical record lacked indication of the physician update, any attempt to gradually reduce the dose of Seroquel, or any active behaviors.

The consultant pharmacist monthly medication regimen review indicated that on 4/21/14, R46's Seroquel was increased to 25 mg twice a day. On 10/15/13, the consultant pharmacist documented to assess Seroquel in one to three months. On 1/15/14, the consultant pharmacist documented there were no behaviors documented. The consultant pharmacist documented monthly

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F 428	Continued From page 13 through 6/12/14, and did not follow up on her recommendations to assess the Seroquel, or to ask the physician for a GDR. On 6/13/14, at 7:53 a.m. registered nurse (RN)-A was interviewed and verified there had been no gradual dose reduction attempted. RN-A further stated the facility should fax the physician yearly and request a GDR. The consultant pharmacist was unavailable for interview. The facility policy and procedure on psychotric drug dose reduction dated 6/10, directed a psychotropic drug dose reduction attempt will be made within the first year, in two separate quarters, (with at least one month between attempts), then annually.	F 428		

594 Cherry Drive • Waconia, MN 55387 • 952.442.2546 • www.auburnhomes.org

DATE: July 11, 2014

SUBJECT: Plan of Correction for the State Nursing Home Licensing and Federal Certification Standard Survey completed at Auburn Home in Waconia, 594 Cherry Drive, Waconia, Minnesota, by the Minnesota Department of Health and Public Safety on June 13, 2014.

It is the policy, and intention, of Auburn Home in Waconia to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed.

F 282
SS=D
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

Auburn Home in Waconia ensures that resident services are provided by qualified persons in accordance with each resident's written plan of care.

R18 had one episode of transferring herself while in her restroom unattended with a subsequent fall on May 10, 2014. The fall did not involve the resident's bed and she has not made attempts at independent transfers since the initial incident. All of the resident beds at Auburn Home are designed so that they may be placed in the low position. The notation in the deficiency that states "R18 did not have a low bed" is incorrect. The issuance of this deficiency was the result of the resident's care plan not being updated and reflects a documentation error. To date, the resident's care plan has been updated to reflect the care that the resident is receiving.

R60's care plan dated 5/1/14 reflected a fall risk related to his terminal status which progressed to his inability to attempt any self-mobility which negates his fall risk. On June 10, 2014, the second day of the survey, R60 was being enrolled in Hospice and his care plan would have changed. The resident no longer needed an audible bed or wheelchair alarm and they were previously discontinued as a

matter of dignity for the resident. This survey finding is the result of the resident's care plan not being updated during the transition to hospice care. The resident's care plan was updated during the survey and the transition to hospice.

Facility Wide Response Affecting All Residents:

1. The facility's interdisciplinary team (IDT) reviews all residents' status on a weekly basis for any changes in condition and identifies care plans that need to be updated. Nurse Managers update the residents' care plans based upon the information collaborated upon during the weekly meetings.
2. The facility's IDT reviews each resident's care plan at least quarterly to ensure that it accurately reflects the level of care the resident is receiving.
3. Fall reduction interventions will be communicated to the direct care staff via the nursing assistant worksheet. All direct care staff will have access to the required worksheets.
4. *Ongoing:* Quarterly random sample audits of residents' care plans will be conducted to ensure the level of care described in the care plan is consistent with the individually assessed needs of the resident. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed July 23, 2014.

F 323
SS=D
483.25(h) FREE OF ACCIDENHT HAZARDS/SUPERVISION/DEVICES

Auburn Home in Waconia ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The survey team noted concerns in the facility's assessment of causal factors for falls, interventions and measures implemented to minimize resident falls, and in the area consistent communication of fall mitigation measures.

R84 was noted to be at risk for falls. The facility had initiated a mat on the floor, bed and wheelchair alarms, and his bed in the low position. Between April 4, 2014 and June 2, 2014, the resident experienced 4 falls. On June 6, 2014, the resident slid out of his wheelchair while watching TV in the dayroom. On June 10, 2014, the resident crawled out of his bed onto his floor mat. An analysis of

the residents fall history and root cause analysis was completed on June 9, 2014, and included the following:

EVALUATION
Summarize potential factors that could have contributed to the fall.
Resident has had numerous falls. Numerous interventions in place--walking program bid and toileting program. Resident loves to be outdoors and is taken outside throughout the day especially when he is getting agitated. Resident is offered snacks. Seat cushion assessed by PT and they didn't recommend a new cushion for him as it would not benefit him in any way. New w/c was also discussed and this would not be a beneft for the resident as it would be more a restraint.

PLAN OF CARE
Describe measures to be taken to prevent further falls.
Spoke with family regarding his routine at home, thinking that may have triggered something--falls appear to be around the same time. They said--he was a truck driver but when he was home he would garden outside.

On June 17, 2014, a perimeter mattress was added to R84's bed. The resident was assessed for orthostatic hypotension and the resident's attending physician was updated on June 18, 2014.

The survey team cited this example as an indication of the facility's not completing an analysis of what the resident's needs may have been before the fall. In response, the facility has now integrated concepts of root cause analysis into all of its 'events' documentation.

R18 fell in her bathroom on May 10, 2014. R18 had been sitting on the toilet, and attempted to transfer unassisted off of the toilet. The subsequent fall risk assessment which was completed on the resident lacked fall prevention interventions. Once again in response, the facility has now integrated concepts of root cause analysis into all of its 'events' documentation.

R60 had two falls on June 7, 2014, related to his terminal condition. His care plan dated 5/1/14 reflected a fall risk related to his terminal status which progressed to his inability to attempt any self-mobility which negates his fall risk. On June 10, 2014, the second day of the survey, R60 was being enrolled in Hospice and his care plan would have changed. The resident no longer needed an audible bed or wheelchair alarms and were previously discontinued as a matter of dignity for the resident. This survey finding is the result of the resident's care plan not being updated during the transition to Hospice care. The resident's care plan was updated during the survey and the transition to Hospice.

All falls were being addressed at the weekly IDT meeting, or sooner if necessary, to determine the appropriateness of interventions to reduce or prevent the prevalence of falls. The facility utilized its electronic medical record to 'open' an 'event' for each fall, but did not 'close' the 'event' once it had been completed. The facility was in compliance with its Policy and Procedure for Falls, as it clearly states that " All residents will be assessed for the potential for falls upon admission, quarterly, annually, & after any fall that occurs resulting in a change in condition." None of the three residents in the sample met any of the aforementioned criteria which would have necessitated the completion of a post fall risk assessment. The facility's policies and procedures were reviewed with necessary revision to facility practices as described in the "Facility Wide Response Addressing Other Residents With the Potential to be Affected" section below.

The survey team noted that the following care area assessments (CAA's) were unsigned and not dated:

R84 4/7/14 Risk for Falls
R18 5/30/14 Risk for Falls
R60 4/9/14 Risk for Falls

In all instances, the survey team was referencing the electronic medical record where facility staff records the assessment data. What the survey team failed to ascertain is that facility staff print the electronic forms and then sign them and place a hard copy in the resident's medical record since the facility does not have the capability to sign the assessment forms electronically (Appendix A). The survey team's citations of omitted dates and signatures are incorrect.

Facility Wide Response Addressing Other Residents With the Potential to be Affected:

1. In addition to 'events' being 'opened' in the electronic medical record for each fall, a post fall assessment and investigation assessment will be initiated also. The risk assessment will include an analysis of the data gathered, including a risk cause analysis of factors associated or potentially contributing to the fall. All 'open' events will be closed once the post fall process has been completed.
2. A fall review committee has been established and meets on a bi-weekly basis to review all residents that have incurred a new fall. Fall reduction interventions will be communicated to the direct care staff via the nursing assistant worksheet. All direct care staff will have access to the required worksheets.
3. *Ongoing:* Quarterly random sample audits of resident falls documentation will be conducted to ensure that fall risk assessments, including root cause analysis, are consistently being completed for all

recorded falls. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed July 23, 2014.

F 329
SS=D
483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Auburn Home in Waconia ensures that each resident's drug regimen is free from unnecessary drugs. Residents of Auburn Home who do use antipsychotic medications do receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these medications.

The survey team noted that R46 had an order for Seroquel and that there had not been a gradual dose reduction attempted. The facility, and the facility's consultant pharmacist, did not identify the dose reduction. The required medication dose reduction has been completed for R46.

Facility Wide Response Addressing Other Residents With the Potential to be Affected:

1. A psychotropic medication review committee has been established and meets on a bi-weekly basis to review all residents who have psychotropic medications prescribed. Part of that review process includes ensuring that medication dose reduction schedules are timely in accordance with facility policy.
2. The director of nursing and consultant pharmacist will meet on a monthly basis to discuss identified concerns with the pharmaceutical regimen of residents and to discuss recommendations.
3. *Ongoing:* Quarterly random sample audits of resident's who have psychotropic medications as part of their medication regimen will be conducted to ensure that gradual dose reductions are being completed timely in accordance with facility policy. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed July 23, 2014.

F 356
SS=C
483.30(e) POSTED NURSE STAFFING INFORMATION

Auburn Home in Waconia does post the nursing department staffing data and has done so since the requirement was enacted several years ago. The format used to post the staffing hours has remained the same since the requirement became effective. The format has not been an issue throughout many compliance surveys of the past years.
The format of posting nursing department hours was changed the same day that the survey team brought their concern to the facility's attention.

Facility Wide Response Affecting All Residents:

1. The facility has revised its policy on the posting of nurse staffing data to include an accurate reflection of the following required information:

   o Facility name.
   o The current date.
   o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
   - Registered nurses.
   - Licensed practical nurses or licensed vocational nurses (as defined under State law).
   - Certified nurse aides.
   o Resident census

   Additionally, facility staff responsible for routinely, as well as for back-up purposes, have been made aware of the updated policy and the necessity to ensure an accurate reflection of the daily resident census is included in the posting. The director of nursing will be responsible, on a daily basis, for the monitoring of the facility's nursing staffing posting compliance with the requirements of F 356.
2. *Ongoing:* Quarterly random audits of the daily posting of nursing staffing and resident census will be conducted to ensure that the posted data is inclusive of all required data as aforementioned. These audits will be conducted as part of the facility's CQI initiative for not less than one year. Data obtained from the CQI process will be reviewed, with recommendations for intervention made, during the quarterly CQI meetings.

Time period for correction: Date of completion not to exceed July 23, 2014.

F 428
SS=D
483.30(e) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist at Auburn Home in Waconia. The pharmacist reports any irregularities to the attending physician, and the director of nursing, and these reports are acted upon.

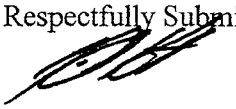
The survey team noted that R46 had an order for Seroquel and that there had not been a gradual dose reduction attempted. The facility, and the facility's consultant pharmacist, did not identify the dose reduction. The required medication dose reduction has been completed for R46.

Facility Wide Response Addressing Other Residents With the Potential to be Affected:

1. A psychotropic medication review committee has been established and meets on a bi-weekly basis to review all residents who have psychotropic medications prescribed. Part of that review process includes ensuring that medication dose reduction schedules are timely in accordance with facility policy.
2. The director of nursing and consultant pharmacist will meet on a monthly basis to discuss identified concerns with the pharmaceutical regimen of residents and to discuss recommendations.
3. *Ongoing:* Quarterly random sample audits of resident's who have psychotropic medications as part of their medication regimen will be conducted to ensure that gradual dose reductions are being completed timely in accordance with facility policy. These audits will be conducted as part of the facility's quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.

Time period for correction: Date of completion not to exceed July 23, 2014.

Respectfully Submitted,



Rick Krant
Administrator

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

F5583022

PRINTED: 06/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING 02 - NEW BLDG B. WING _____	06/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 June 13, 2014. At the time of this survey, Auburn Home in Waconia was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	(See Attached) Pack JB 7-16-14 RECEIVED JUL 11 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 7-23-14

EXIT: 6-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Administrator		7/14/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING 02 - NEW BLDG B. WING _____	06/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Auburn Home in Waconia was constructed in 2007, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	7-23-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. BUILDING 02 - NEW BLDG B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999). In a fire or other emergency, this deficient practice could adversely affect 37 of 37 residents. FINDINGS INCLUDE: On 06/13/2014 at 1:05 PM, during a review of the emergency generator monthly inspection and testing log for the previous one-year period, it was confirmed that loading of the generator did not achieve at least 30% of the EPS nameplate rating. This finding was confirmed with the chief building engineer.	K 144		

Auburn
HOME in WACONIA

SERVING SENIORS
IN THE SPIRIT OF CHRIST'S LOVE

594 Cherry Drive • Waconia, MN 55387 • 952.442.2546 • www.auburnhomes.org

DATE: July 11, 2014

SUBJECT: Plan of Correction for the Life Safety Code Survey completed at Auburn Home in Waconia, 594 Cherry Drive, Waconia, Minnesota on June 13, 2014 by the Minnesota State Fire Marshal's Office.

It is the policy, and intention, of Auburn Home in Waconia to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101(2000).

K 144 NFPA 101 LIFE SAFETY CODE STANDARD

Auburn Home in Waconia conducts weekly generator inspections and exercises it under load for 30 minutes per month in accordance with NFPA 99; 3.4.4.1

On 6/13/14, during the Life Safety Code Survey, the following concern was noted:

A) During a review of the emergency generator monthly inspection and testing log for the previous one-year period, it was noted that loading of the generator did not achieve at least 30% of the EPS nameplate rating.

Plan of Correction:

1. Load bank testing will be completed on the generator prior to the date certain of the correction order. The chief engineer for the facility will be responsible for ensuring ongoing compliance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999).

Timeline for Correction: Date of completion not to exceed July 23, 2014.

Respectfully Submitted,

Rick Krant
Administrator

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5163

June 27, 2014

Mr. Rick Krant, Administrator
Auburn Home in Waconia
594 Cherry Drive
Waconia, Minnesota 55387

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5583022

Dear Mr. Krant:

The above facility was surveyed on June 9, 2014 through June 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3794
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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 feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File