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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LMPW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245604**
2.STATE VENDOR OR MEDICAID NO.
(L2) **422243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN MANOR**
(L4) **501 OAK STREET**
(L5) **CHASKA, MN** (L6) **55318**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/25/2014** (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 **61** (L18)

13.Total Certified Beds **61** (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
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR Social Worker Specialist 10/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5604

Electronically Delivered: October 2, 2014

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

Dear Mr. Krant:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 16, 2014, the above facility is certified for:

61 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61skilled 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 about this electronic notice.

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: October 2, 2014

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

RE: Project Number S5604024

Dear Mr. Krant:

On August 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 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 September 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR), and on October 1, 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 August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2014, effective September 16, 2014 and therefore remedies outlined in our letter to you dated August 20, 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 about this electronic notice.

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
245604	A. Building B. Wing	9/25/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/16/2014**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	10/02/2014	30923	09/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/7/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00335	A. Building B. Wing	9/25/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **09/16/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **09/16/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **09/16/2014**
ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **09/16/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	10/02/2014	30923	09/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
8/7/2014	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
245604	01 - MAIN BUILDING 01	10/1/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/16/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	10/02/2014	22373	10/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/7/2014

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
245604	02 - 2006 ADDITION	10/1/2014

Name of Facility	Street Address, City, State, Zip Code
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/16/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 10/02/2014	**Signature of Surveyor:** 22373	**Date:** 10/01/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/7/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 2, 2014

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

Re: Reinspection Results - Project Number S5604024

Dear Mr. Krant:

On September 25, 2014 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 August 7, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 about this electronic notice.

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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LMPW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245604**
2.STATE VENDOR OR MEDICAID NO.
(L2) **422243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUBURN MANOR**
(L4) **501 OAK STREET**
(L5) **CHASKA, MN** (L6) **55318**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/07/2014** (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 **61** (L18)

13.Total Certified Beds **61** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NE II 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/16/2014 (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
08/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/17/2014 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

Electronically Delivered: August 20, 2014

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

RE: Project Number S5604024

Dear Mr. Krant:

On August 7, 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:

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

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

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

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

months after the survey date; and

<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, Supervisor
Metro D Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 16, 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 September 16, 2014 the following remedy will be imposed:

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

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.

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 November 7, 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 February 7, 2015 (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 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	08/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a change in continence for 1 of 2 residents (R37) who were reviewed for bladder incontinence. Findings include:	F 315	It is the policy, and intention, of Auburn Manor in Chaska 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	9/16/14

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

Electronically Signed | 08/30/2014

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F 315	Continued From page 1 R37 was observed during an interview on 8/5/14, at 9:00 a.m. The resident appeared clean, dry and odor free. R37's admission Minimum Data Set (MDS) assessment was completed 2/19/14. The bladder care area (section H0300) listed R37 as "always continent" of bladder. The admission bladder observation documentation, dated 2/24/14, indicated that R37 had two incontinent episodes with in the first 24 hours of admission and none since. The resident wore an incontinent product at night only. He required assistance of two staff to use the bathroom, and was able to use the call light appropriately. R37 was assisted to the toilet with morning and evening cares, before and after meals, per request, and as needed during the night. The following quarterly MDS dated 5/22/14, listed R37 as frequently incontinent (seven or more episodes) and the resident was not on a bladder program designed to improve function. The quarterly MDS nursing documentation dated 5/23/14, however, did not address a change in continence as noted on the MDS. The notation did indicate R37 required assistance of staff with activities such as grooming and toileting, and was stable and free from acute changes. A nursing assistant (NA)-A was interviewed on 8/6/14, at 1:00 p.m.. He explained that R37 was continent of bladder, and was able to use the call light to let staff know when he needed assistance. At 1:30 p.m. a registered nurse (RN)-B responsible for completing R37's assessment was interviewed. He stated R37 had been prescribed a diuretic (medication to reduce excess body fluids) and that had caused an	F 315	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. Auburn Manor provides appropriate bladder incontinence assessments, treatments, and services to prevent urinary tract infections and to restore and/or maintain as much normal bladder function as possible. The survey team noted that the facility did not address a change in continence for one resident who was reviewed for bladder incontinence. Resident 37 had an admission Minimum Data Set (MDS) Assessment completed 2/19/14. Prior to the completion of the MDS, there had been a bladder/incontinence assessment completed on the resident. The bladder assessment at the time of admission revealed that the resident was frequently incontinent of urine. The RN responsible for completing the resident's assessment MDS indicated that he had erroneously coded the resident as continent of bladder at the time of admission. The quarterly	

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F 315	Continued From page 2 increase in urinary frequency. A review of the medication orders revealed that a diuretic had been ordered on 2/28/14, and the order had not changed or been discontinued. The plan of care for R37 indicated a potential problem related to the need for assistance with dressing, grooming, bathing, toileting and transfers. The goal was for the residents' needs to be met. Approaches included: anticipate needs and address them; encourage and allow resident to participate with all cares as tolerated; explain all cares and ensure understanding prior to providing assistance. The plan of care lacked any specific problem or interventions related to a change in his continence. MDS nurse RN-C was interviewed on 8/7/14, at 12:00 p.m. She stated that with a change from continent to frequently incontinent, she would have expected a bowel and bladder study and assessment of the findings to have been completed. RN-C then reviewed the medical record for R37 and verified a study and assessment had not been completed at the time of the quarterly assessment.	F 315	MDS dated 5/22/14 was coded correctly and there would not have been nursing documentation to support a change in continence since there wasn't any since the time of admission. The resident was frequently incontinent at the time of admission as the admission bladder assessment supports. The facility will initiate services in an effort to restore and/or maintain as much of Resident 37's bladder function as possible. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility staff responsible for completing the MDS will review resident assessment and MDS completion practices to enhance comprehensive accuracy. 2. Residents identified as being incontinent of bladder will receive services to restore and/or maintain as much normal bladder function as possible. 3. Ongoing: Quarterly random sample audits of resident□s' Minimum Data Set Assessments will be conducted to ensure that they are being completed accurately, in accordance with facility policy. The facility will also audit those residents who have been assessed to have bladder incontinence to ensure that they have received services to restore and/or maintain as much bladder function as possible.	

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F 315	Continued From page 3	F 315	Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure justification for	F 329	Auburn Manor ensures that each resident□s drug regimen is free from	9/16/14

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F 329	Continued From page 4 the continued use of of antipsychotic and sedative medication for 1 of 5 residents (R17) who were reviewed for unnecessary medications. Findings include: R17 was interviewed while in bed on 8/6/14, at 10:00 a.m. She was very slow to answer questions and her speech frequently drifted. The resident presented with a wide-eyed stare and often looked away from the surveyor. R17 said she felt her current medications were "fine." She offered very little information during the interview, but did say staff encouraged her to get out of bed. R17's current medications included haloperidol (antipsychotic for Haldol) 0.5 at bedtime, Xanax (anti-anxiety medication) 0.125 three times daily, Ambien (sedative) 5 milligrams at bedtime, and Celexa (antidepressant) 20 mg, with a history of severe depression, psychosis and anxiety. On 7/19/13, R17's haloperidol was changed from as needed (PRN) to a scheduled dose each night. The change was made due to R17's frequent requests for the medication at night. Reasons the resident requested the medication was documented as, helping with with sleep and for nervousness and anxiety. At the time of the change, there was no indication in the medical record that alternative measures had been initiated to alleviate her anxiety and sleeplessness. R17's physician's progress notes revealed that R17 had been seen on 10/4/13. At that time, the antipsychotic medication Abilify was discontinued, as the resident said it made her ache all over. The physician noted that R17 had life-long	F 329	unnecessary drugs. Residents of Auburn Manor who do use antipsychotic medications do receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these medications. Although Resident 17's physician did document the justification for the current, resident directed, medication regimen on 10/4/13, the facility conducted a pharmaceutical consultation with the facility's consultant pharmacist following the survey. Following the consultation, the facility contacted Resident 17's physician and has requested clarification for the continued resident-directed medication regimen with the inclusion of the physician's direction regarding the avoidance of future medication dose reductions as it relates to her current 'effective' medication regimen and clinical contraindication. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Auburn Manor's Psychotropic Medication Review Committee will continue to meet on a weekly basis to review residents who have psychotropic medications prescribed in preparation for the identified residents quarterly care conference. Every resident is evaluated by the committee on a quarterly basis. Part of that review process includes ensuring that medication dose reduction	

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F 329	Continued From page 5 depression that was unlikely to change and to continue with current medications. R17's sleep logs were reviewed. The most recent was completed on 3/22/14, and indicated the resident received adequate sleep. The resident tolerated a decrease in R17's Xanax on 5/17/14 to 0.125 mg three times daily without issues. R17's annual Minimum Data Set (MDS) assessment dated 6/6/14 showed the resident displayed mood symptoms nearly every day during the assessment time period. Also on 6/6/14 a note by social services staff indicated a visit with the resident was conducted. The resident's cognitive assessment noted her cognition was intact and a depression assessment indicated severe depression. The resident was offered but declined mental health services (also offered 4/8/14), but did accept visits from the chaplain. The annual social services summary also dated 6/6/14, indicated the resident continued self-care, however, chose to stay in her room and declined group and most independent activities. A 6/6/14 activity note revealed the resident listened to music, occasionally looked at magazines, but complained books were too heavy for her to hold. She spent all of her time in her room with the shades pulled. A care conference held on 6/25/14, and it was noted R17 refused to attend or to hold the conference in her room. (The resident and her son did attend the previous conference on 3/26/14 which was held in her room.) R17's current care plan noted the potential for isolation,	F 329	schedules are timely in accordance with facility policy. 2. The director of nursing and consultant pharmacist will meet on a monthly basis to review psychotropic medication utilization and pharmacy recommendations and possible reduction strategies. 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, and/or necessary documentation exists for the clinical contraindication for further attempts at medication reduction, in accordance with facility policy. The facility will also consider whether 'The medication regimen helps promote or maintain the resident□'s highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff', as defined in the interpretive guidelines at F 329. 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.	

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F 329	Continued From page 6	F 329		

staying in room with the drapes pulled, the use of multiple psychoactive medications and repetitive health complaints, ineffective coping skills related to chronic pain, anxiety and depression.

The social service designee (SSD) was interviewed on 8/6/14, at 11:15 a.m. She explained that the resident had been living in an assisted living apartment with her husband/primary caregiver who died in the fall. When the facility's previous psychologist retired, she refused to see another psychologist. In the past facility staff had some successes in engaging the resident in conversation or opening the blinds for short periods of time.

A registered nurse (RN)-B was interviewed on 8/6/14, at 1:47 p.m. and stated R17 had psychosis repetitive health complaints. Her physician had followed her for over 40 years and said she remained the same. The resident reported she could not sleep due to fearfulness and anxiety, therefore, the physician changed her haloperidol from as needed to scheduled (7/19/13).

The director of nursing (DON) was interviewed on 8/7/14, at 8:37 a.m. She explained that R17 had requested the change in haloperidol from as needed to scheduled. The resident was very knowledgeable about her medication schedule, and could be come angry with proposed changes. Additionally, R17 had a history of becoming very verbally aggressive when she did not get what she wanted. The DON felt that R17 was currently stable and not obsessed with health issues. Sleep logs were then reviewed and the DON confirmed the resident was sleeping well. The DON explained

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F 329	Continued From page 7 that facility staff had not assessed the need for the increase in haloperidol, rather the resident had requested it be changed. The consulting pharmacist (CP)-A was interviewed on 8/7/14, at approximately 10:00 a.m. He explained that haloperidol had been started 10/10/10 with annual trial reductions in 2011, 2012, and 2013. In 7/13 the medication was changed to routine and the Xanax had been recently been reduced (5/13). R17 had long standing severe mental health issues with major depression. CP-A said he had been in attendance with staff at psychotropic medication reviews. The resident was doing well, and perhaps they could look at a reduction in the resident's haloperidol or Ambien if she was sleeping well. Although CP-A felt the use of haloperidol was justified, he did not believe a justification had been documented in the resident's medical record.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of fewer than 5% for 2 of 6 residents (R17, R75) whose medication administration was observed. This resulted in a medication error rate of 16%.	F 332	It is the intention of Auburn Manor to ensure that residents are free of medication errors to the extent possible. The facility provides medication administration in accordance with accepted protocols and practices consistent with accepted standards of	9/16/14

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F 332	Continued From page 8 Findings include: R75's medications were administered on 8/7/14 at approximately 7:35 a.m. by a trained medication aide (TMA)-A. The medications included levothyroxine (for Synthroid, to regulate thyroid function) 50 micrograms (mcg) orally once a day. The directions on the medication card directed staff to give the medication on an empty stomach. The medication was crushed, stirred into pudding and given with approximately 100 cubic centimeters (cc) of house nutritional supplement (HNS--a high protein, high calorie supplement to potentiate nourishment). At 7:45 a.m. R75 was assisted to the dining room and ate breakfast, finishing at 8:10 a.m. R75's diagnostic list printed on 8/7/14 included hypothyroidism. R17's medications were administered at 7:46 a.m. by TMA-A while the resident was in her room. The medications were crushed, stirred into pudding and given with 120 cc's of HNS. R17's medication included carafate 1 gram (for ulcers), levothyroxine 50 mcg, and Reglan 5 mg (for gastroesophageal reflux disease). The medication cards directed staff to administer carafate 1 hour before or 2 to 3 hours after a meal, levothyroxine on an empty stomach, and Reglan 30 minutes before a meal. At 7:55 a.m. R17 was served breakfast. R17's diagnostic list printed 8/7/14 included hypothyroidism and peptic ulcer. The medical doctor's (MD) order for for carafate (dated 4/29/14), directed staff to administer prior to other medications. The MD order for levothyroxine (dated 11/26/11), directed staff to give on an empty stomach. The MD order for Reglan (dated 4/3/14), directed staff to administer before a	F 332	nursing practice. Auburn Manor's Medication Administration Policy and Procedure directs staff to administer medications that are to be given on an empty stomach using the Omnicare provided guideline "Drug Administration Recommendations Regarding Food", physician orders, and manufacturer's recommendations. Upon facility analysis of these survey findings, it was determined that contributing factors to these findings included isolated individual variances from the accepted medication administration standards of practice as outlined in the facility'□s pharmacy policies and procedures. In response, the individual involved, as well as all TMA's and nurses will be counseled and re-educated on facility policy and procedure and acceptable medication administration practices. Facility Wide Response Affecting All Residents: 1. To ensure medication administration practices consistent with time parameters as ordered, facility staff responsible for medication administration will be re-educated on the necessity to follow medication orders as written by the physician or according to manufacturer's recommendations. 2. To ensure medication administration	

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F 332	Continued From page 9 meal. Product information at http://www.webmd.com/drugs/drug noted Reglan should have been taken 30 minutes before meals and at bedtime, usually 4 times daily or exactly as directed by the MD. This web information also stated carafate should have been taken by mouth, usually 2 to 4 times daily, on an empty stomach at least 1 hour before a meal, or as directed by the MD. Product information at https://www.synthroid.com/prescription/tips.aspx revealed levothyroxine should have been taken on an empty stomach, being best taken 30 to 60 minutes before eating breakfast. The Omnicare pharmacist consultant (PC)-A was interviewed on 8/7/14 at 9:45 a.m. PC-A explained that medications should not be administered with HNS when instructions are to administer away from food. PC-A stated he did not have an issue when Synthroid was administered with food as long as thyroid stimulating hormone (TSH) laboratory results were monitored annually and remained stable. On 8/7/14, at 11:30 a.m. the assistant director of nursing (ADON) and assistant manager (AM)-A stated administering medications on an empty stomach would typically mean 30 minutes before a meal or 2 to 3 hours after a meal, with specific orders superceding this. The ADON further explained the facility staff had not been advised or trained as to whether it was acceptable to give medications away from food with HNS, but expected the TMAs to follow the guidelines and directions from the pharmacist, as well as the medication cards and MD orders.	F 332	practices are consistent with facility policies and procedures and standards of practice, facility staff responsible for medication administration will be re-educated on the necessity to follow medication administration orders with an emphasis on drug administration regarding food. 3. Ongoing: Random medication administration audits of a selected resident sample will occur on a quarterly basis. The audits will focus on adherence to the facility□s medication administration policies and procedures. The Pharmacy Nurse Consultant (PNC) will conduct quarterly medication administration audits for compliance purposes. Medication errors will be investigated and tracked in an effort to track potential patterns and identify potentially modifiable contributing factors. These audits will be conducted as part of the facility□s quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	

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	245604	A. BUILDING _____ B. WING _____	08/07/2014

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

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F 332	Continued From page 10 On 8/7/14 at 12:55 p.m., TMA-A stated R17 ate in her room, and the person giving the resident her meal tray would not know when her medications had or had not been given. TMA-A stated she wished the facility had a practice of doing so, but she had not informed any of the staff to wait prior to giving a resident their meals. HSN had not been considered a food, because it was a liquid. TMA-A said she had been running late in administering R17 her medications, so she "just gave it." The Auburn Manor Medication Administration Policy & Procedure revised 1/1/13, 6.2 Medication Administration Times effective date 12/1/07, directed staff to administer ordered before meals approximately thirty (30) minute before meal time. The facility was to refer to the medication administration policy to determine whether certain medicines required different administration times. On 8/11/14 at 3:20 p.m. during a phone conversation, R75's medical doctor (MD)-C stated the best practice when administering levothyroxine is to give it 30 minutes before a meal.	F 332		
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.	F 356		9/16/14

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F 356	Continued From page 11 - 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. 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 60 residents residing in the facility, as well as family members or the general public. During the initial observation tour of the facility on 8/4/14, at 12:40 p.m. the posting of nursing staffing hours listed the shifts, for example "day," however, the shifts did not specify specific hours for the shifts licensed personnel were working such as 7:00 a.m. to 3:30 p.m.	F 356	Auburn Manor's standard of practice regarding the posting of nurse staffing information includes all of the requirements at F 356. Facility Wide Response Affecting All Residents: 1. The facility has revised its policy on the posting of nurse staffing data to include the actual specific hours for the day shift, evening shift, and night shift. Additionally, facility staff responsible for	

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F 356	Continued From page 12 On 8/6/14, at 11:00 a.m. the director of nursing was interviewed and verified the posted hours did not refelct the specific hours worked by the licensed staff.	F 356	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 actual specific hours for the day, evening, and night shifts' posting. The director of nursing will be responsible for the monitoring of the facility□s nursing staffing posting's compliance with the requirements of F 356. 2. Ongoing: Quarterly random audits of the daily posting of nursing staffing 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 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.	
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		9/16/14

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F 428	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist addressed irregularities related to the lack of physician justification for the continued use of of antipsychotic and sedative medication for 1 of 5 residents (R17) who were reviewed for unnecessary medications. Findings include: R17's current medications included haloperidol (antipsychotic for Haldol) 0.5 at bedtime, Xanax (anti-anxiety medication) 0.125 three times daily, Ambien (sedative) 5 milligrams at bedtime, and Celexa (antidepressant) 20 mg, with a history of severe depression, psychosis and anxiety. On 7/19/13, R17's haloperidol was changed from as needed (PRN) to a scheduled dose each night. The change was made due to R17's frequent requests for the medication at night. Reasons the resident requested the medication was documented as, helping with with sleep and for nervousness and anxiety. At the time of the change, there was no indication in the medical record that alternative measures had been initiated to alleviate her anxiety and sleeplessness. R17's physician's progress notes revealed that R17 had been seen on 10/4/13. At that time, the antipsychotic medication Abilify was discontinued, as the resident said it made her ache all over. The physician noted that R17 had life-long depression that was unlikely to change and to continue with current medications.	F 428	Auburn Manor ensures that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physician, and the director of nursing, for appropriate follow through. Although Resident 17's physician did document the justification for the current, resident directed, medication regimen on 10/4/13, the facility conducted a pharmaceutical consultation with the facility's consultant pharmacist following the survey. Following the consultation, the facility contacted Resident 17's physician and has requested clarification for the continued resident-directed medication regimen with the inclusion of the physician's direction regarding the avoidance of future medication dose reductions as it relates to her current 'effective' medication regimen and clinical contraindication. Facility Wide Response Affecting All Residents: 1. The facility has a psychotropic and antipsychotic review committee which reviews the drug regimen of every resident who has these medications prescribed. The committee reviews drug regimens to ensure that residents who	

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F 428	Continued From page 14 R17's sleep logs were reviewed. The most recent was completed on 3/22/14, and indicated the resident received adequate sleep. The resident tolerated a decrease in R17's Xanax on 5/17/14 to 0.125 mg three times daily without issues. A registered nurse (RN)-B was interviewed on 8/6/14, at 1:47 p.m. and stated R17 had psychosis repetitive health complaints. Her physician had followed her for over 40 years and said she remained the same. The resident reported she could not sleep due to fearfulness and anxiety, therefore, the physician changed her haloperidol from as needed to scheduled (7/19/13). The director of nursing (DON) was interviewed on 8/7/14, at 8:37 a.m. She explained that R17 had requested the change in haloperidol from as needed to scheduled. The resident was very knowledgeable about her medication schedule, and could be come angry with proposed changes. Additionally, R17 had a history of becoming very verbally aggressive when she did not get what she wanted. The DON felt that R17 was currently stable and not obsessed with health issues. Sleep logs were then reviewed and the DON confirmed the resident was sleeping well. The DON explained that facility staff had not assessed the need for the increase in haloperidol, rather the resident had requested it be changed. The consulting pharmacist (CP)-A was interviewed on 8/7/14, at approximately 10:00 a.m. He explained that haloperidol had been started 10/10/10 with annual trial reductions in 2011, 2012, and 2013. In 7/13 the medication	F 428	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. Additionally, residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions unless clinically contraindicated, in an effort to discontinue these drugs. If discrepancies are noted, the respective resident'□s attending physician is notified for appropriate response and action. 2. If attending physician□s fail to respond to the above mentioned committee□'s or consulting pharmacist□'s concerns and recommendations, the facility'□s medical director will be consulted for appropriate follow-through. 3. Ongoing: As noted in response #1, ongoing monthly psychotic and antipsychotic reviews will continue for all residents receiving these medications. Review results will be further discussed, with recommendations made, during the quarterly quality assurance meetings.	

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F 428	Continued From page 15 was changed to routine and the Xanax had been recently been reduced (5/13). R17 had long standing severe mental health issues with major depression. CP-A said he had been in attendance with staff at psychotropic medication reviews. The resident was doing well, and perhaps they could look at a reduction in the resident's haloperidol or Ambien if she was sleeping well. Although CP-A felt the use of haloperidol was justified, he did not believe a justification had been documented in the resident's medical record.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		9/16/14

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F 431	Continued From page 16 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to indicate expiration dates on 2 medication bottles for one resident (R51) in 1 of 4 medication carts. Findings include: The facility's medication storage system was observed with a registered nurse (RN)-A on 8/4/14, at 1:48 p.m. Two medication bottles labeled for R51 lacked expiration dates. Both medications were from Rainbow Pharmacy, one was labeled "bumetanide 1 mg" (milligram) and the other was labeled "metoprolol ER 25 mg." RN-A stated she would call the pharmacist to determine the expiration dates. The following day on 8/5/14, at 2:15 p.m. RN-A explained that R51's family had brought in the Rainbow-sourced medications for R51's use. "What we have done [since yesterday] is to order them from Omnicare like our others, and the family said to throw the ones from Rainbow away." RN-A stated the director of nursing indicated they should not have stored medications for use that lacked expiration dates.	F 431	The standard of practice at Auburn Manor is that drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, including expiration dates. The survey team observed two medication bottles for one resident in one of four medication carts to be lacking expiration dates. RN-A immediately called the pharmacist to determine the expiration dates. Both medications had been brought in by the family and were from a retail-based pharmacy which typically does not provide medications to the facility. The majority of the facility's pharmaceuticals are provided by Omnicare who packages and labels the medications in a manner that is consistent with the facility's medication administration systems. All of these factors contributed to the missed expiration date.	

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F 431	Continued From page 17	F 431	In response to this finding, the family agreed to having Omnicare as the resident's primary pharmaceutical provider and instructed facility staff to destroy the aforementioned bottles of medications. Facility Wide Response Affecting All Residents: 1. To ensure that medications are labeled in accordance with currently accepted principles,facility staff responsible for medication administration will be re-educated on the necessity to review all medication labels for consistency and inclusion of all required information, including expiration dates. The nurse in charge will immediately notify the pharmacy if a labeling error has been identified. 2. Ongoing: Random medication labeling and storage audits will occur on a quarterly basis. The Pharmacy Nurse Consultant (PNC) will conduct quarterly medication labeling and storage audits for compliance purposes. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings.	

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	245604	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**08/07/2014**

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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 FORM 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, Fire Marshal Division, on August 7, 2014. At the time of this survey, Building 02 of Auburn Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2014

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.

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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. Building 02 of Auburn Manor consists of a 2006 building addition, which 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 nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 61 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		9/16/14

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K 050	Continued From page 2 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 18, Section 18.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 61 of 61 residents. FINDINGS INCLUDE: On 08/07/2014 at 11:50 AM, while reviewing fire drill reports for the previous year, no documentation could be provided verifying that fire drills were conducted on the Night-Shift during September and October 2013, or June, July and August 2014. This deficient practice was confirmed with the chief building engineer.	K 050	It is the policy, and intention, of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101(2000). K 050 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualilfied to exercise leadership. On 8/7/14 it was noted that the facility had not completed a required fire drill during September and October 2013, or June, July, and August 2014. Plan of Correction: 1. Facility staff responsible for conducting	

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K 050	Continued From page 3	K 050	quarterly fire drills have reviewed and have been re-educated on the requirement addressing fire drills in the 101 Life Safety Code Standard and facility policy and procedure. 2. The facility□s chief engineer will be responsible for conducting quarterly fire drills on each shift at unexpected times., and completing all required documentation. The facility□s safety committee will monitor fire drills both scheduled and completed at the facility to ensure that the requirement is met on an ongoing basis.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF FORM 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, Fire Marshal Division, on August 7, 2014. At the time of this survey, Building 01 of Auburn Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/07/2014**

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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. Building 01 of Auburn Manor is a one-story building with no basement. The original building was constructed in 1988, with one building addition constructed in 1992. Both buildings are fully fire sprinkler protected and were determined to be of Type II(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 nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 61 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		9/16/14

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K 050	Continued From page 2 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was confirmed the facility failed to conduct one or more fire drills on each shift, during each quarter of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 61 of 61 residents. FINDINGS INCLUDE: On 08/07/2014 at 11:50 AM, while reviewing fire drill reports for the previous year, no documentation could be provided verifying that fire drills were conducted on the Night-Shift during September and October 2013, or June, July and August 2014. This deficient practice was confirmed with the chief building engineer.	K 050	It is the policy, and intention, of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101(2000). K 050 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualilfied to exercise leadership. On 8/7/14 it was noted that the facility had not completed a required fire drill during September and October 2013, or June, July, and August 2014. Plan of Correction:	

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K 050	Continued From page 3	K 050	1. Facility staff responsible for conducting quarterly fire drills have reviewed and have been re-educated on the requirement addressing fire drills in the 101 Life Safety Code Standard and facility policy and procedure. 2. The facility□s chief engineer will be responsible for conducting quarterly fire drills on each shift at unexpected times., and completing all required documentation. The facility□s safety committee will monitor fire drills both scheduled and completed at the facility to ensure that the requirement is met on an ongoing basis.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: August 20, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5604024

Dear Mr. Krant:

The above facility was surveyed on August 4, 2014 through August 7, 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.

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

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

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 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, 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