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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TJZS
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 **05/19/2016** (L34)

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	

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245583

May 23, 2016

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

Dear Mr. Krant:

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

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

Effective May 10, 2016 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.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2016

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

RE: Project Number S5583024

Dear Mr. Krant:

On April 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2016. Most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2016, effective May 10, 2016 and therefore remedies outlined in our letter to you dated April 14, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245583		5/19/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 05/10/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 05/10/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 05/10/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 05/10/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 05/10/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/10/2016
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 (INITIALS) GD/kfd	DATE 05/23/2016	SIGNATURE OF SURVEYOR 18623	DATE 5/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/31/2016	☐ 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
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TJZS
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 **03/31/2016** (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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 05/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

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

RE: Project Number S5583024

Dear Mr. Krant:

On March 31, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 10, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 ______	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		5/10/16

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

Electronically Signed — 04/22/2016

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 ______	03/31/2016

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 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) to reflect falls for 1 of 3 residents (R55) reviewed for falls. Findings include: During an observation on 3/30/16, at 6:59 a.m., R55's alarm sounded as he climbed out of bed and landed on his knees. R55 then grabbed the top drawer in a three drawer stand and pulled himself to a standing position, he then fell back to his knees. The surveyor alerted staff to R55's fall. During an observation on 3/31/16, at 7:30 a.m., R55 was observed climbing out of bed. R55 climbed to his knees and then stood. Staff responded to alarm and intervened. R55's significant change MDS dated 2/18/16, indicated he was cognitively impaired and required assistance with all activities of daily living. The MDS further indicated R55 had not had any falls since the previous assessment three months prior. A review of Auburn Home facility Progress Notes dated January 2016, through March 31, 2016, indicated during the month of January, R55 had occurrences described as "climbing" out of bed,	F 278	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. One surveyor noted that R55's medical record indicated that R55 had a history of "wandering" around his room, "crawling" out of bed, and "rolling" out of bed. The surveyor continued to state on the Summary Statement of Deficiencies that there were no post fall investigations completed for these incidents nor was there evidence of any root cause analys8s	

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 ______	03/31/2016

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 278	Continued From page 2 "sliding" out of bed, "wandering" about his room, and "rolling" out of bed on ten separate occasions. During the month of February 2016, the Progress Notes indicated 17 incidence of R55 "wandering" around his room, "crawling" out of bed, and "rolling" out of bed. There were no post fall investigations completed for these incidents nor was there evidence of any root cause analysis to determine possible contributing factors. During the month of March 2016, R55 had the following falls. On 3/7/16, he was found crawling around on the dining room floor at 7:00 a.m. A post fall Progress Note indicated "high fall risk", would become physically aggressive with staff, and "does well with music therapy and this will continue to be an intervention." On 3/12/16, the Progress Notes indicated R55 self-transferred out of wheel chair and "tripped on foot rests." A post fall Progress Note dated 3/14/16, indicted R55 "forgets he is not to self-transfer." The note further indicated he facilities fall intervention program would be initiated, however, the interventions included in the facilities fall intervention program included music, floor mats, low bed, alarms, anti-lock brakes and ambulation which were previously implemented interventions. A Progress Note dated 3/19/16, indicated R55 was found lying on the floor on his back in the dining room. A post fall Progress Note dated 3/22/16, indicated R55 would be evaluated for a "wedge" wheel chair cushion, however registered nurse (RN)-A stated on 3/31/16, at 8:17 a.m. "he's [R55] on hospice and hospice doesn't pay for that." The cushion was not initiated as an intervention. During an interview on 3/31/16, at 7:28 a.m.,	F 278	to determine possible contributing factors. Contributing factors to this finding included facility staff concurring that when R55 had been found on his floor mat the behavior which led to his being found in this position was both intentional and purposeful. R55 will slide on to his floor mat, get to his hands and knees on the mat and then pull himself up to a standing position using the bed frame. These behaviors were not being recognized by facility staff as constituting a fall and thus were not followed-up upon as a fall or coded on the MDS as being a fall. R55's MDS was modified and corrected on 4/5/16. Facility Wide Response Affecting All Residents: 1. The facility s interdisciplinary team (IDT) and licensed nursing staff have been educated on the definition of a fall according to the MDS 3.0 manual dated October, 2015. The facility's policy and procedure for care planning has also been revised and updated to include the MDS 3.0 Manual's definition of falls. 2. When residents are found on the ground or in unusual places or positions, facility staff will conduct a post-fall assessment of the findings utilizing a root cause analysis approach to determine appropriate interventions and follow-through. The facility s IDT reviews each incident and makes a determination as to whether or not the post-fall	

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 ______	03/31/2016

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 278	Continued From page 3 RN-C stated R55 had an alarm that went off and alerted staff if he climbed out of bed which she stated "is typical" for R55. She stated staff also kept his door open and "the alarm watches him if no one is around." RN-C stated in regard to R55's falls from bed, "if he is on his knees on the mat with his alarm sounding, it is not considered a fall." During an interview on 3/31/16, at 8:00 a.m., RN-A stated there was no pattern to R55 climbing out bed and stated, "He just does that." RN-A stated if R55 was found on his mat it was not considered a fall even though it was not witnessed by staff. During an interview on 3/31/16, at 2:07 p.m., the director of nursing (DON) stated she did not know if R55 was climbing out of bed or sliding out of bed. The DON stated his multiple incidents of rolling out of bed should have been coded as falls. While R55 had multiple incidents of rolling out of bed during the months of January and February of 2016, the MDS was coded as no falls since previous assessment. A facility policy related to accurate coding of the MDS was requested, but none was available. The MDS 3.0 manual dated October 2015, defined a fall: "Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not	F 278	assessment findings are consistent with the MDS 3.0 Manual's definition for a fall and whether or not the incident is reflected in the progress notes and whether or not faciliy staff should proceed to care plan. 4. Ongoing: Quarterly random sample audits of residents medical records will be conducted to ensure appropriate fall identification, documentation, and interventions based upon root cause analysis are reflected for all incidents which meet the MDS 3.0 Manual's definition of a fall. These audits will be conducted as part of the facility s quality assurance initiative for not less than one year. Data obtained from the quality assurance process will be reviewed, with recommendations for interventions made, during the quarterly quality assurance meetings.	

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 ______	03/31/2016

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 278	Continued From page 4 a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person - this is still considered a fall."	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan regarding interventions to reduce falls for 1 of 3 residents (R55) reviewed for accidents and 1 of 2 residents (R16) reviewed for pressure ulcers.	F 280	One surveyor noted that the facility did not revise the care plans regarding interventions to reduce falls for one resident in the sample and one resident in the sample reviewed for pressure ulcers.	5/10/16

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 ______	03/31/2016

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 280	Continued From page 5 Findings include: R55's significant change Minimum Data Set (MDS) dated 2/18/16, indicated he was cognitively impaired and required assistance with all activities of daily living (ADLs). A Care Area Assessment (CAA) dated 2/18/16, indicated R55 was at risk for falls related to difficulty maintaining standing position, impaired gait, balance, and use of psychotropic medications. R55's care plan dated 3/14/16, indicated risk for falls and directed staff to give verbal reminders not to transfer without assistance and incorporate the facilities fall management program which included offers of toileting, food, music, games, rest and alarms. During the month of March 2016, R55 had the following falls. On 3/7/16, he was found crawling around on the dining room floor at 7:00 a.m. A post fall Progress Note dated 3/7/16, indicated "high fall risk", will become physically aggressive with staff, and "does well with music therapy and this will continue to be an intervention." On 3/12/16, the Progress Note indicated R55 self-transferred out of wheel chair and "tripped on foot rests." A post fall progress note dated 3/14/16, indicted R55 "forgets he is not to self-transfer." The note further indicated the facilities fall intervention program would be initiated, however, the interventions included in the facilities fall intervention program included music, floor mats, low bed, alarms, anti-lock brakes and ambulation which were previously implemented interventions. A Progress Note dated 3/19/16, indicated R55 was found lying on the floor on his back in the dining room. A post fall progress note dated 3/22/16, indicated R55 would be evaluated for a "wedge" wheelchair cushion,	F 280	Upon further in-depth review of the resident's medical record, completed by facility staff, the care plan interventions referenced for R55 on 3/14/16 were resident-specific individualized interventions developed in conjunction with his wife, not those of a pre-established 'facilities fall management program.' Following the fall of 3/12/16 the resident had a medication adjustment since the IDT suggested the medication contributing to the incident of 3/12/16. In addition to the resident-specific interventions described in the 3/14/16 care plan, the Ruby Slipper Program had also been initiated on this resident. On 3/23/16, following the recorded fall of 3/22/16, the resident received a high-back wheelchair with anti-locking brakes. The facility also had provided the resident with a cushion the facility had in stock. The surveyor cited that R16 was identified as being at risk for ulcers and had a history of chronic lower extremity ulcers and that there was no evidence of interventions implemented to decrease the risk of ulcers and that the left heel protector was not included on the resident's plan of care. Facility staff is unaware of what the surveyor was referencing when she cited, 'nor was it revised to include floating of the heels.' In response to the other components of this cited deficiency, the resident did have lamb's wool on the foot of his bed and the left heel proctector was routinely placed	

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 ______	03/31/2016

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 280	Continued From page 6 however registered nurse (RN)-A stated on 3/31/16, at 8:17 a.m. "He's [R55] on hospice and hospice doesn't pay for that." R55's care plan was not revised to include the wheelchair cushion as an intervention and nor did the facility supply one. R16's A CAA dated 11/30/15, indicated R16 had chronic sores on his lower extremities that were healed. The care plan dated 11/30/15, identified a risk for pressure ulcers related to immobility, incontinence, poor vascular flow to lower extremities and elevated blood sugars. The care plan directed staff to conduct a skin assessment "particular attentions" to lower extremities. The care plan further directed staff to provide R16 with a pressure reducing cushion in his chair and ace wraps to legs. R16's facility Treatments Flowsheets dated January 2016, through March 2016, indicated in January R16 had two open areas below his left knee, a wound on his left great toe, and an open area on his right toe. During the month of February R16 had the two open areas below his left knee and an open area to his right toe. March treatment records indicate two open areas below R16's left knee, an open area to his right toe, an open area to his left 2nd toe and an ulcer on his left heel. R16's quarterly MDS dated 2/1/16, indicated he was moderately cognitively impaired, required extensive assist with all ADLs and had diabetic foot ulcers. A review of an On-site Podiatry progress noted	F 280	during cares. The intervention for heel protectors was in the electronic medical record and was placed on the treatment kardex beginning April 1st. The resident does have a tendency to kick-off the heel protector. The resident refused Ace Wraps while in bed and was on Hospice care at the time of the survey. Wound orders were in place for diabetic ulcers at the time the surveyor cited that there was no evidence of interventions implemented to decrease the risk of ulcers for R16. In-depth medical record review by facility staff revealed that R16 was seen by the podiatrist on 3/11/16, had Hospice documentation regarding wound interventions on 3/4, 3/11, 3/22, and 3/29/16. In addition, R16's nurse practitioner addressed his diabetic ulcers during her visit on 3/23/16. In the spirit of cooperation, the facility is submitting the following Facility Wide Response Which Could Potential Affect All Residents: 1. Facility staff have reviewed the following facility protocol: if facility staff discovers a skin concern they should report to the facility wound nurse. Anything greater than a stage one ulcer should be put on the treatment record and should have ongoing updates on progress. 2. 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	

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 ______	03/31/2016

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 280	Continued From page 7 dated 3/11/16, indicated R16 had an ulcer on his left 3rd toe and his left heel. The progress note directed staff to clean the ulcers, apply prescribed treatments and obtain a heel protector for the left foot for use in bed and wheel chair. The progress note further indicated R16 had a diabetic ulcer. "In this case, the diabetic ulcer also has a significant pressure component." The plan of care was not revised to include the left heel protector and nor was it revised to include the floating of the heels. A review of a facility progress note dated 3/14/16, indicated R16 had two open areas on his left foot. One on the medial side of his heel measuring 2 centimeters (cm) x 2.4 cm x 0.1 cm. Wound bed described as containing 75% slough. The ulcer on R16's second toe described as 0.6 cm x 0.6 cm x 0.1 cm with 100% slough covering the wound bed. During an observation on 3/30/16, at 10:20 a.m., R16 was lying in bed. R16's right foot had open areas on his toes, inside of his left heel and a red area on the bottom of his heel. The 3rd toe of R16's left foot had a black area. R16 did not have the ace wraps the legs, there was no left heel protector on the foot, and both heels were resting on the mattress. During an interview on 3/30/16, at 10:45 a.m., RN-A stated she was responsible for taking care of skin and wounds. She stated if someone has an open area on their skin she would do an assessment, take measurements and set up a treatment plan. The treatment plan did not include the heel protector update. During an interview on 3/31/16, at 1:18 p.m., the	F 280	residents' care plans based upon the information collaborated upon during the weekly meetings. 3. 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. 4. 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. 5. 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.	

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 ______	03/31/2016

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 280	Continued From page 8 director of nursing (DON) stated if a nurse discovers a skin concern she would report to RN-A. She stated anything greater than a stage one ulcer should be put on the treatment record and should have ongoing updates on progress. While R16 was identified for being at risk for ulcers and had a history of chronic lower extremity ulcers, there was no evidence of interventions implemented to decrease the risk of ulcers. A facility policy titled Auburn Home In Waconia Policy and Procedure For Care Planning-Initial Care Conference, dated April 2015, was reviewed. The policy indicated staff would develop a multidisciplinary plan of care consistent with the physician's orders to meet the resident's individual needs and interests. The policy directed staff to identify short term goals for each need/problem and implement approaches to assist with achieving the goal. The long term goal reflects the attainment of short term goals.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		5/10/16

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 ______	03/31/2016

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 314	Continued From page 9 Based on observation, interview and document review, the facility failed to implement interventions to reduce the risk of pressure ulcers for 1 of 2 residents (R16) reviewed for pressure ulcers. Findings include: During an observation on 3/30/16, at 10:20 a.m., R16 was lying in bed. R16's right foot had open areas on his toes, inside of his left heel and a red area on the bottom of his heel. The 3rd toe of R16's left foot had a black area. R16 did not have the ace wraps on the legs, there was no left heel protector on the foot, and both heels were resting on the mattress. A Care Area Assessment (CAA) dated 11/30/15, indicated R16 had chronic sores on his lower extremities that were healed. R16's care plan dated 11/30/15, identified a risk for pressure ulcers related to immobility, incontinence, poor vascular flow to lower extremities and elevated blood sugars. The care plan directed staff to conduct a skin assessment "particular attentions" to lower extremities. The care plan further directed staff to provide R16 with a pressure reducing cushion in his chair and ace wraps to legs. The care plan did not address protection for R16's legs and feet even though assessments had identified chronic ulcers. R16's quarterly Minimum Data Set (MDS) dated 2/1/16, indicated he was moderately cognitively impaired, required extensive assist with all activities of daily living and had diabetic foot ulcers. A review of an On-site Podiatry progress noted	F 314	As noted in the plan of correction at F280, the resident did have lamb's wool on the foot of his bed and the left heel proctector was routinely placed during cares. The intervention for heel protectors was in the electronic medical record and was placed on the treatment kardex beginning April 1st. The resident did have a tendency to kick-off the heel protector. The resident refused Ace Wraps while in bed and was on Hospice care at the time of the survey. Wound orders were in place for diabetic ulcers at the time the surveyor cited that there was no evidence of interventions for the diabetic ulcers. In-depth medical record review by facility staff revealed that R16 was seen by the podiatrist on 3/11/16, had Hospice documentation regarding wound interventions on 3/4, 3/11, 3/22, and 3/29/16. In addition, R16's nurse practitioner addressed his diabetic ulcers during her visit on 3/23/16. These interventions were not reflected on the resident's care plan inadvertently. Upon discovery, the resident's care plan was updated to reflect all of the interventions identified in the resident's medical record. Facility Wide Response Which Could Potential Affect All Residents: 1. Facility staff have reviewed the following facility protocol: if facility staff discovers a skin concern they should report to the facility wound nurse. Anything greater than a stage one ulcer should be put on the treatment record and interventions reflected on the individual	

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 ______	03/31/2016

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 314 Continued From page 10

dated 3/11/16, indicated R16 had an ulcer on his left 3rd toe and his left heel. The progress note directed staff to clean the ulcers, apply prescribed treatments and obtain a heel protector for the left foot for use in bed and wheel chair. The progress note further indicated R16 had a diabetic ulcer. "In this case, the diabetic ulcer also has a significant pressure component."

A review of a facility progress note dated 3/14/16, indicated R16 had two open areas on his left foot. One on the medial side of his heel measuring 2 centimeters (cm) x 2.4 cm x 0.1 cm. Wound bed described as containing 75% slough. The ulcer on R16's 2nd toe described as 0.6 cm x 0.6 cm x 0.1 cm with 100% slough covering the wound bed.

A review of facility Treatments Flowsheets dated January 2016, through March 2016, indicated in January R16 had two open areas below his left knee, a wound on his left great toe, and an open area on his right toe. During the month of February R16 had the two open areas below his left knee and an open area to his right toe. March treatment records indicate two open areas below R16's left knee, an open area to his right toe, an open area to his left 2nd toe and an ulcer on his left heel.

During an interview on 3/30/16, at 9:48 a.m., registered nurse (RN)-B stated R16 had a "superficial" wound to the side of his heel and scattered scabs on his legs and arms and open areas on the ends of his toes.

During an interview on 3/30/16, at 10:45 a.m., RN-A stated she was responsible for taking care of ski and wounds. She stated if someone has an

F 314

resident's plan of care with ongoing updates on progress reflected in the resident's medical record.

2. 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.

3. 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.

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.

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 ______	03/31/2016

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 314	Continued From page 11	F 314		

open area on their skin she would do an assessment, take measurements and set up a treatment plan. She stated open areas should be monitored weekly depending on the extent of the wound. RN-A stated she looked at R16's ulcers on 3/14/16, but had not seen him since. During a subsequent interview on 3/31/16, at 9:52 a.m., RN-A stated she was not sure when R16's heel ulcer developed. She stated she became aware of it on March 14th.

During an interview on 3/31/16, at 1:18 p.m., the director of nursing (DON) stated if a nurse discovers a skin concern she would report to RN-A. She stated anything greater than a stage one ulcer should be put on the treatment record and should have ongoing updates on progress. While R16 was at risk for ulcers and had a history of chronic lower extremity ulcers, there was no evidence of ongoing assessment nor was there evidence of interventions to decrease the risk of ulcers.

A facility policy titled, Auburn Home in Waconia Policy and Procedure For Skin Assessment, dated April 2013 was reviewed. The policy indicated every resident will be assessed on a regular basis for the risk for skin breakdown. If skin breakdown occurs a a procedure will follow to assure ongoing assessments of the wound and effectiveness of the ordered treatment. Charting in the progress notes should be done to reflect any and all changes. An RN or wound care team will assess the progress of the problem or wound as needed. A policy for pressure related ulcers was requested but none was received.

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 ______	03/31/2016

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 314	Continued From page 12	F 314		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to reduce the risk of falls for 1 of 3	F 323	R55 has a diagnosis of Lewy Bodies Dementia and his behavior of sliding, crawling, and rolling out of bed are	5/10/16

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 ______	03/31/2016

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 323

Continued From page 13

residents (R55) who sustained multiple falls in the facility.

Findings include:

During an observation on 3/30/16, at 6:59 a.m., R55's alarm sounded as he climbed out of bed and landed on his knees. R55 then grabbed the top drawer in a three drawer stand and pulled himself to a standing position, he then fell back to his knees. Surveyor alerted staff to R55's fall. Registered nurse (RN)-C entered R55's room and stated, "Do you want to get back into bed for now?" RN-C put R55 back to bed, covered him up, turned on his call light and left the room. At 7:06 a.m., R55's alarm sounded again and required staff intervention.

During an observation on 3/31/16, at 7:30 a.m., R55 was observed climbing out of bed. R55 climbed to his knees and then stood. Staff responded to alarm and intervened.

R55's significant change Minimum Data Set (MDS) dated 2/18/16, indicated he was cognitively impaired and required assistance with all activities of daily living. A Care Area Assessment (CAA) dated 2/18/16, indicated R55 was at risk for falls related to difficulty maintaining standing position, impaired gait and balance, and use of psychotropic medications. R55's care plan dated 3/14/16, indicated risk for falls and directed staff to give verbal reminders not to transfer without assistance and incorporate the facilities fall management program which included offers of toileting, food, music, games, rest and alarms.

A review of Auburn Home facility Progress Notes dated January 2016, through March 31, 2016,

F 323

consistent characteristics of his behavior at this point in his disease process.

Upon further in-depth review of the resident's medical record, completed by facility staff, the care plan interventions referenced for R55 on 3/14/16 were resident-specific individualized interventions developed in conjunction with his wife, not those of a pre-established 'facilities fall management program.' Following the fall of 3/12/16 the resident had a medication adjustment since the IDT suggested the medication contributing to the incident of 3/12/16. In addition to the resident-specific interventions described in the 3/14/16 care plan, the Ruby Slipper Program had also been initiated on this resident. On 3/23/16, following the recorded fall of 3/22/16, the resident received a high-back wheelchair with anti-locking brakes. The facility also had provided the resident with a cushion the facility had in stock.

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

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 ______	03/31/2016

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 323	Continued From page 14 indicated during the month of January 2016, R55 had occurrences described as "Climbing" out of bed, "sliding" out of bed, "wandering" about his room, and "rolling" out of bed on ten separate occasions. During the month of February 2016, progress notes indicated 17 incidence of R55 "wandering" around his room, "crawling" out of bed, and "rolling" out of bed. There were no post fall investigations completed for these incidents nor was there evidence of any root cause analysis to determine possible contributing factors. During the month of March 2016, R55 had the following falls. On 3/7/16, he was found crawling around on the dining room floor at 7:00 a.m. A post fall progress note indicated "high fall risk", will become physically aggressive with staff, and " does well with music therapy and this will continue to be an intervention." On 3/12/16, progress notes indicated R55 self-transferred out of wheelchair and "tripped on foot rests." A post fall progress note indicted R55 "forgets he is not to self-transfer." The note further indicated he facilities fall intervention program would be initiated, however, the interventions included in the facilities fall intervention program included music, floor mats, low bed, alarms, anti-lock brakes and ambulation which were previously implemented interventions. A progress noted dated 3/19/16, indicated R55 was found lying on the floor on his back in the dining room. A post fall progress note indicated R55 would be evaluated for a "wedge" wheel chair cushion, however RN-A stated on 3/31/16, at 8:17 a.m. "he's [R55] on hospice and hospice doesn't pay for that." The cushion was not initiated as an intervention. During an interview on 3/31/16, at 7:28 a.m.,	F 323	post fall process has been completed. 2. A fall review committee has been established and meets on a bi-monthly 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.	

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 ______	03/31/2016

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 323	Continued From page 15 RN-C stated staff keep in close contact with hospice regarding R55's falls. She stated R55 sleeps in until he wakes on his own and when he is awake "we get the Ativan and Seroquel right away." She stated, if we don't, "He has behaviors." RN-C stated R55 has an alarm that goes off and alerts staff if he climbs out of bed which she stated "is typical" for R55. She stated staff also keep his door open and "the alarm watches him if no one is around." RN-C stated in regard to R55's falls from bed, "if he is on his knees on the mat with his alarm sounding, it is not considered a fall." During an interview on 3/31/16, at 8:00 a.m., RN-A stated when R55 first came her he never fell. She stated, "He had a decline, and started to fall." RN-A stated there was no pattern to R55 climbing out bed and stated, "He just does that." RN-A stated if R55 was found on his mat it is not considered a fall even though it was not witnessed by staff. During an interview on 3/31/16, at 2:07 p.m., the director of nursing (DON) stated, R55 was progressing in his disease quickly. She stated she did not know if he was climbing out of bed or sliding out of bed. The DON stated his multiple incidents of rolling out of bed should have been treated as falls.	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	F 329		5/10/16

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 ______	03/31/2016

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 329	Continued From page 16 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 a gradual dose reduction was attempted for 1 of 5 residents (R49) reviewed for unnecessary medications use. Findings include: R49 was observed on 3/30/16, at 7:02 a.m. sitting in a wheelchair (w/c) in the common area across from the nursing station watching television. R49 was noted to appear calm. - 7:52 a.m. R49 sitting in w/c in the dining room eating her breakfast. Conversing with other residents. - 8:34 a.m. facility staff wheeled R49 out of the dining room. R49 ate 100% of her breakfast.	F 329	One surveyor noted that one resident in the sample did not have a dose reduction attempt, in the last year, for her prescribed antidepressant medication. It is the expectation, by contract language, of the facility that the consulting pharmacist is to review all resident's medications on a monthly basis for any irregularities, including recommending gradual medication dose reduction of certain medications. In the particular case of R49, the consulting pharmacist indicated that a gradual medication dose reduction for R49 during the past year was omitted.	

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 ______	03/31/2016

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 329	Continued From page 17 - 10:06 a.m. R49 participating and engaged in a recreational activity. - 11:00 a.m. R49 participating and engaged in a recreational activity. On 3/31/16, at 7:40 a.m. R49 was observed sitting in a w/c in the common area across from the nursing station watching television. R49 was noted to appear calm. - 7:42 a.m. facility staff wheeled R49 to the dining room for breakfast. - 8:17 a.m. R49 sitting in w/c in the dining room eating her breakfast. Conversing with other residents. - 8:37 a.m. R49 wheeled self from the dining room. R49 ate 100% of her breakfast. - 9:40 a.m. R49 participating and engaged in a recreational activity. A review of R49's current Physicians Orders revealed a Physician Order dated 6/28/14, indicating R49 received Remeron (anti-depressant medication) 15 milligrams (mg) by mouth at bedtime for depression. Review of R49's consulting pharmacist's monthly medication regimen review from 4/17/15, to 3/18/16, did not address continued use of Remeron. R49's progress notes from 10/7/15, to 3/31/16, were reviewed indicated that R49 had no signs/symptoms of depression, mood changes or behaviors noted in that time period. R49's annual Minimum Data Set (MDS) dated 11/9/15, and quarterly MDS dated 1/25/16, both indicated R49 had no symptoms of depression. R49's diagnoses included depressive disorder, anxiety disorder, insomnia and chronic pain	F 329	At the time this finding was brought to the attention of facility staff, a call was placed to R49's medical provider. The following response was received from the medical care provider and placed in R49's medical record: "Benefits of Remeron use outweigh risk as resident's mood/depression scores have been stable since this medication. No dose reduction indicated at this time, as it is required for her mood stabilizing. She was started on this when she was on hospice & resident continues to be comfort focus cares." Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. The psychotropic medication review committee meets on a bi-monthly 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 routine basis monthly, during the consultant pharmacist's facility visit, to discuss recommendations and medication review 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	

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 ______	03/31/2016

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 329	Continued From page 18 obtained from the quarterly MDS dated 1/25/16. R49's Mood and Behavior Evaluation, dated 11/9/15, & 1/25/16, both indicated R49 exhibited no signs/symptoms of depression, mood changes or any behaviors. When interviewed on 3/30/16, at 1:05 p.m., nursing assistant (NA)-A stated R49 did not have any moods or behaviors. When interviewed on 3/30/16, at 1:17 p.m., registered nurse (RN)-B stated R49 does not have any behaviors or signs or symptoms of depression. RN-B further stated R49 "used to get teary, but has not done that for a long time, months and months." When interviewed on 3/31/16, at 8:44 a.m., the unit nurse manager, RN-A stated R49 was admitted to the facility with a Physician Order for Remeron 15 mg. RN-A continued to state that R49 had no signs or symptoms of depression. When asked if R49 had any behaviors, RN-A stated R49 "she is perfect" and did not have any behaviors. During interview on 3/31/16, at 12:02 p.m. the facility's director of nursing stated the expectation is for the consulting pharmacist to review all resident's medications on a monthly basis for any irregularities. When asked if R49 had any signs or symptoms of depression DON stated "she is always happy, has not had episodes of weepiness for a long time." The facility's undated policy titled "ST THERESE PHARMACY POLICY AND PROCEDURE" indicated that the medication regimen review for	F 329	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.	

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 ______	03/31/2016

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 329	Continued From page 19 each resident will be performed at least once a month. The policy directed that pharmacist to document irregularities or no irregularities in the resident's clinical record and to report any irregularities to the attending clinical prescriber and the director of nursing and these reports must be acted upon.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/10/16

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 ______	03/31/2016

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 441	Continued From page 20 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to sanitize glucometer to prevent the spread of blood borne pathogens for 4 of 5 residents (R13, R87, R84, R10). This has the potential to affect 11 resident residents in the facility who have glucometer checks done. Findings include: R13's Admission Minimum Data Set (MDS) dated 3/3/16, indicated R13 was alert and oriented with a diagnosis of diabetes. During observation of glucometer (a machine used to check blood sugars) check on 3/30/16, at 7:30 a.m. registered nurse (RN)-C asked R13 to allow blood sugar to be checked. RN-C brought caddy with supplies including the glucometer in a black carrying case, into the small dining room on Lake Station. RN-C wiped the glucometer with a sanitizing wipe prior to using. RN-C wiped R13's finger on right hand with alcohol swab, pricked the finger with a lancet and obtained a drop of blood. After completing the blood sugar check RN-C placed glucometer in black carrying case without cleaning it and put the caddy on the nurse ' s station desk and assisted R13 to breakfast.	F 441	The surveyor's finding at F441 is attributed to inconsistent blood glucose meter cleaning practices and the need for revision to the existing blood glucose cleaning policy and procedure and staff education. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. The existing policy and procedure for clearning of blood glucose machines was revised and updated, during the survey, to match the germicidal wipes manufactures instructions. 2. Facility staff responsible for cleaning of the blood glucose machines will be re-educated on acceptable cleaning practices of the blood glucose monitors consistent with the facility's policy addressing this process. 3. Oversight for compliance with the facility s blood glucose monitoring standard of practice will be the conducted by the nurse managers.	

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 ______	03/31/2016

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 441

Continued From page 21

R87's undated Resident Face Sheet indicated R87 had a diagnosis of diabetes. The Physician Orders Report for 2/29/16 through 3/31/16, indicated R87 was to have accuchecks (blood sugars) done four times a day.

On 3/30/16, at 7:43 a.m. RN-C put caddy with blood sugar supplies on R87's bed. RN-C explained what RN-C was going to do and offered R87 a choice of fingers. R87 wiped the third finger on left hand with alcohol, poked finger with lancet and collected drop of blood. RN-C removed gloves, wiped glucometer with sani wipe for 15 seconds then put glucometer in caddy in black zipped bag. RN-C washed hands in bathroom. R87 gave RN-C a piece of gauze to throw away. (RN)-C put caddy down on counter in R87's bathroom without a barrier and threw gauze away and washed hands. RN-C wheeled R87 to the dining room and then put caddy away in the cupboard.

R84's undated Resident Face Sheet indicated R84 had diagnoses of diabetes and pneumonia unspecified organism. Order History List printed, 3/31/16, indicated R84 had completed antibiotic treatment on 3/27/16.

During observation of glucometer check on 3/30/16, at 7:54 a.m. RN-C put caddy on R84's bed by the footboard. RN-C wiped the glucometer off with a sani-wipe for three seconds, then put the glucometer on bedside table without a barrier. RN-C put on gloves, wiped the second finger of R84's right hand with alcohol, poked finger with lancet and collected drop of blood. RN-C removed gloves, wiped glucometer with sani wipe

F 441

4. All residents will receive an individual blood glucose meter which is exclusively used on the assigned resident only. Cleaning of the blood glucose meter will be according to policy and procedure, per manufacturer's guidelines. Once the resident discharges, the blood glucose meter will receive a terminal cleaning according to facility policy and procedure.
5. Ongoing: Quarterly random sample audits of staff responsible for blood glucose monitoring will be conducted by the facility's infection control specialist to ensure compliance with the facility's blood glucose meter usage and cleaning policy and procedures. 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.

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 ______	03/31/2016

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 441	Continued From page 22 for seven seconds then blew on it. RN-C put glucometer in the black carrying case and put the case in the caddy. RN-C came out to desk put caddy in the cupboard and washed hands. During interview on 3/30/16, at 8:01 a.m. (RN)-C said, "I clean the glucometer before I take the test because I don't know if it was cleaned by the person before me and then I clean it after collecting the blood. I wipe it off and allow it to air dry. It takes about 3 minutes." RN-C acknowledged wiping the glucometer for less than 30 seconds and immediately placed glucometer in black case after each wiping. RN-C did not know how long the glucometer stayed wet in the case. RN-C acknowledged blowing on glucometer after wiping it off and stated should not have done so because of infection control risks. During interview on 3/30/16, at 8:04 a.m. the director of nurses (DON) said expected staff to first wipe off visible dirt from glucometer with a cloth then use the germicidal sani wipe. The glucometer was to be cleaned and allowed to remain wet for three minutes and then allow to air dry. The DON said nursing staff should not put the glucometer in the black carry case while it was still damp. DON verified that each unit had only one glucometer that staff used for all residents on the unit. During interview on 3/31/16, at 3:07 p.m. with administrator and DON, the DON said, "We have had discussions about glucometers. We have looked at having their own glucometers but thought too expensive due to high cost due to high number of admissions." The DON acknowledged the policy was revised today to	F 441		

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 ______	03/31/2016

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 441	Continued From page 23	F 441		

match the manufactures instructions. The administrator stated the facility would look at getting individual glucometers for long term residents and dedicated glucometers for each short term resident and would disinfect glucometers upon discharge of short term residents before using for the next resident.

R10's significant change MDS dated 3/7/16, indicated she was cognitively intact and required supervision and set up help to complete activities of daily living. A review of R10's Physician Orders indicated she received Blood glucose checks four times daily.

During an observation on 3/28/16, at 4:27 p.m., RN-D entered R10's room to perform a blood glucose check. RN-D applied gloves, checked R10's blood glucose and returned the glucometer to a plastic bin containing, lancets and a cup with cotton balls. RN-D did not disinfect the glucometer prior to placing it in the plastic bin.

During an interview on 3/28/16, at 4:39 p.m., RN-D stated there were four people on the unit with blood glucose checks at that time. She stated one other residents glucose check was completed prior to checking R10's. RN-D stated the facilities glucometer was shared between residents and the glucometers get cleaned on the overnight shift. She stated the glucometers were not cleaned between residents and that she did not clean the glucometers on her shift.

During an interview on 3/28/16, at 4:42 p.m., the DON stated glucometers should be cleaned after every resident use using germicidal wipes.

The Policy and Procedure for Cleaning and

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 ________	03/31/2016

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 441	Continued From page 24 Disinfection of Glucometers dated 6/10, instructed staff to "1. Clean glucometer surface when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material. 2. If no visible organic material is present, disinfect the exterior surface after each use with SANI-CLOTH PLUS."	F 441		

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

F5583024

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING	(X3) DATE SURVEY COMPLETED 03/29/2016

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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 29, 2016. At the time of this survey, Auburn Home in Waconia was found 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. 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 MET as evidenced by:	K 000		

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

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.