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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WSUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **61** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 09/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/10/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245604

October 29, 2015

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

Dear Mr. Krant:

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

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

Effective September 8, 2015 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 17, 2015

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

RE: Project Number S5604025

Dear Mr. Krant:

On July 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 16, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 16, 2015, effective September 8, 2015 and therefore remedies outlined in our letter to you dated July 27, 2015, 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 related to this eNotice.

Sincerely,

Mark Meath

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building B. Wing	9/8/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/08/2015**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/08/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	09/17/2015	30923	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/16/2015			

Minnesota Department of Health

Certified Mail # 7015 0640 0003 5695 5132

November 16, 2015

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

Subject: Auburn Manor - IDR
CMS Certification Number (CCN): 245604
Project Number: S5604025

Dear Mr. Krant:

This is in response to your letter of August 6, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F221 and F425 issued pursuant to the survey event WSUP11, completed on July 16, 2015.

The information presented with your letter, the CMS 2567 dated July 16, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F221 S/S – (D) 42 CFR §483.13(a) Restraints: The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

Summary of the facility's reason for IDR of this tag:
The facility alleges the perimeter mattress for R38 and R23 did meet the restraint requirements as the mattress serves as a reminder to both residents to ask for assistance to transfer out of the bed and the perimeter mattress did not restrict the freedom of movement of both residents.

Summary of facts:
At the time of survey, perimeter mattress (with raised edges) was in use and the facility did not conduct an assessment of the mattress to determine if the mattress was a potential restraint for R38 and R23.

Summary of findings:
The facility provided documentation for both residents (R38 and R23) from the Minimum Data Set (MDS) for the definition of restraints, from the State Operations Manual, Appendix PP, a mobility and functional level assessment from both the occupational and physical therapy department that the perimeter mattresses did not impose or restrict both residents.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F425 S/S – (D) 42 CFR § 483.60(a)(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH :
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

Summary of the facility's reason for IDR of this tag:
The facility alleges the facility policy met the requirements of the administration of the inhaled medication. The facility submitted manufacturer's instructions and their policy. The facility policy read, "Wait approximately 1 minute between puffs OR as ordered by the physician OR according to manufacturer's recommendation." In addition, the facility indicated R61 was alert and oriented and had been utilizing the inhaler since January of 2015. Therefore, R61 would not have needed to be instructed for the inhaler technique.

Summary of facts:
At the time of survey, based on observation, interview, and document review, the TMA failed to instruct R61 on the proper technique for the use of inhaler.

Summary of findings:
Even though the trained medication aide (TMA) shook the inhaler canister prior to and in between puffs according to the manufacturer's recommendation, the TMA failed to ensure the resident received the full benefit of medication. The AstraZeneca instructions (for Symbicort) revised 8/13, directed the user to breathe out or exhale completely then hold the canister up to the mouth. Then place the lips around the mouthpiece. The user was then to inhale deeply and slowly through the mouth and pressing down on the top of the Symbicort to release the medication for ten seconds. This ensured the user received the full benefit of the medication. In addition, manufacturer's instructions directed the user, "Do not use SYMBICORT unless your healthcare provider has taught you and you understand everything."

R61's Minimum Data Set (MDS) dated 4/23/15, indicated R61 was cognitively intact. However, it was also documented that R61 was slightly hard of hearing, requiring the speaker to speak in loud tone of voice as R61 would miss some or part of the intent of the message. The TMA did not instruct R61 to exhale and inhale as to receive the maximum benefit from the medication. The TMA did not follow the facility policy which was to follow the Symbicort manufacturer's guidelines for medication administration.

F425 is a valid deficiency at this tag and at the correct scope and severity of (D).

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792 Fax: 651-201-3790

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gayle Lantto, Metro Team D Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was within reach for 1 of 2 (R21) residents reviewed for environmental concerns. Findings include: On 7/13/15, at 2:45 p.m. R21 was observed lying on her back with the head of the bed raised slightly, watching a television. Her call light was	F 246	Auburn Manor respects each resident's right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The survey team cited one instance when they 0bserved R21's call light to be on the	8/25/15

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

Electronically Signed | 08/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1	F 246		

next to her on the bed, which she was able to locate with verbal cues from the surveyor.

Later that evening at 7:14 p.m. R21 was in her room sitting in her wheelchair next to her bed. The doors to her room were open, and the resident could be visualized from the hallway. She was dressed in a T-shirt and incontinence brief and her bare legs were out in front of her on the chair leg rest. She was reaching toward the bed with her left hand. The call light was out of the resident's reach on the floor behind the wheelchair. At 7:17 p.m. a nursing assistant (NA) came into the room and asked R21 what she could do to help. Without picking up the call light, the NA hurriedly left R21's room stating, "I'll be right back." At 7:20 p.m. the NA came down the hall with a second NA, but instead of returning to R21's room, the two NAs went into the adjacent resident room.

At 7:28 p.m. the surveyor asked a registered nurse (RN)-A to observe the location of R21's call light. RN-A picked up the light and verified it should not have been left on the floor out of R21's reach. She explained, "She is fidgety and she probably threw it off her. They [NAs] should have pinned it on her chair," which RN-A then did. RN-A said R21 probably could not have used the call light effectively, and added she was normally, "under staff eyes when up in the wheelchair during the day." RN-A said R21 was admitted after a fall with hip fracture, and had experienced one fall at the facility.

R21 had been newly admitted to the facility from the hospital. The initial Minimum Data Set revealed the resident had been experiencing delirium symptoms (an acute abnormal mental

floor and out of reach of the resident. This resident is known to become restless and will throw her call light on the floor at times. Contributing factors to this finding includes the call light's cord clip failing from, what more than likely was, the force of the resident's pulling on the cord and throwing it. This was an isolated event supported by the number of other times the surveyor described the call light being within the resident's reach as noted in the example. This event was incidental in nature and not a result of a failed practice or facility system. Residents' call lights being within reach is the standard of care at Auburn Manor and all staff understand the importance and necessity of this.

The call light cord clip was replaced immediately upon its discovery and had been noted to be functioning properly during the remainder of the survey, again as noted throughout the surveyor's example.

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

1. Facility staff will be provided a reminder of the necessity to ensure that resident's call lights are always within the resident's reach. This will be accomplished using the facility's electronic learning system.

2. Charge nursing personnel will be responsible for ongoing compliance of call lights being within reach by doing visual monitoring of resident room's for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2 state often associated with infection) with fluctuating cognition. On 7/15/15, at 9:52 a.m. NA-F stated R21 was able to use her call light and did use her call light. NA-F also stated in fact, "Sometimes she gets 'call light happy.'" NA-F further stated when R21 was out of her room, the call light was clipped to the bed and when R21 sat in her recliner, staff clipped the call light to the recliner. At time of interview R21's call light was observed clipped onto the bed sheet at the head of R21's bed. On 7/15/15, at 11:35 a.m. the director of nursing (DON) was interviewed. She explained that residents who were unable to use their call lights would have been out of their rooms "where staff can see them...staff should round on them to see if they have any needs during the night, or naps in bed during the daytime." She added, "I would expect that to show in the care plan. It's not likely to be in the policy. Specific rounding times should be in the care plan." When asked whether call light audits had been performed she said she would need to speak to the director of maintenance, "because he does more of the technical side." Since she took over the position of director of nursing 5/18/15, DON stated she had not performed any call light audits. The DON also stated she expected staff to follow facility policies. In addition, she expected call lights to be placed in reach of residents who were able to use them. When asked if she would expect care plans to indicate whether a resident could not use the call light she responded, "No, I have not had that expectation because...my thought is that they are always in reach."	F 246	appropriate call light placement. 3. Ongoing: Quarterly random sample audits of correct call light placement will be conducted utilizing the facility's Resident and Room Safety Audit Tool (Appendix E). Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	
F 371	483.35(i) FOOD PROCURE,	F 371		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=F	Continued From page 3 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow procedures to ensure that sanitation occurred during the dishwashing process and consistently monitor dishwasher temperatures. In addition, the facility failed to ensure that freezers and refrigerators were kept clean and that opened food was dated. This had the potential to affect all 60 residents that resided in the facility. Findings include: On 7/14/15, at 9:56 a.m. during a follow-up tour of the kitchen, a dietary aide (DA)-A was observed running dishes through the dishwasher. The wash tank temperature was noted to be 132 degrees Fahrenheit (F), the rinse tank temperature at 142 degrees F and the final rinse temperature was 132 degrees F. DA-A ran about four additional loads of plates through the dishwasher machine and the temperatures remained the same as above. At the same time, DA-B was taking dishes sent through the dish machine and began storing them for use. The surveyor intervened and asked	F 371	Auburn Manor does procure food from sources approved or considered satisfactory by Federal, State and local authorities and stores, prepares and distributes that food under sanitary conditions. On 7/14/15, the survey team noted that the dishwasher in the kitchen was not heating to required temperatures. The facility's dietary manager was consulted and determined that the dishwasher booster heater had been turned off. Contributing factors to this finding included a new dietary staff member being involved in the finding. The dietary aid stated that she was nervous with the survey process and forgot to turn on the booster heater. Once the booster heater was turned on and the water temperatures reached required levels, all dishes that would have been affected by the water temperatures not reaching required levels were re-washed at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 DA-A to look at the dishwasher temperature gauge and verify it was not heating to the required temperatures. Following the observation, DA-A stated that she expected the washer temperatures to be between 150-160 degrees and the final rinse temperatures to be above 180 degrees. DA-A reported she had checked the temperatures "this morning before breakfast and the machine was working okay." On 7/14/15, at 10:11 a.m. the dietary manager (DM) verified that the dishwasher temperatures were 142 degrees F for the wash cycle and 132 degrees F for the final rinse. DM stated that "the booster might be off." The DM then checked on the booster and verified that it had been turned off. She turned the booster on and asked DA-A to run empty trays through the dishwasher machine. After running three empty trays, the wash temperature was recorded at 152 degrees F and the final rinse at 190 degrees F. The surveyor then requested the dishes previously washed be re-washed at the proper temperature. The 7/15, dish machine temperature log was reviewed on 7/13/15, at 1:13 p.m. The log revealed temperatures were supposed to have been recorded three times daily at breakfast, lunch and dinner. Data was unrecorded for three days for breakfast, four days for lunch and seven days for dinner between 7/1 and 7/13/15. The DM verified the inconsistencies in monitoring of the dishwasher temperatures. During a follow-up interview on 7/15/15, at 12:57 p.m. the DM reported all dietary employees had been trained on using dishwasher and how to log temperatures. Here expectations were that	F 371	proper temperatures. This was directed by the facility's dietary manager and not the surveyor as stated in the example. In response to the above findings, the dietary manager is personally training each new dietary team member on turning on the booster heater and making sure it is on for each shift. In addition, the dietary manager has re-trained her staff on checking dishwasher temperatures every shift and report irregularities to the dietary manager immediately. In addition, the dietary manager monitors the temperature logs for completion daily. During the initial tour of the kitchen, on 7/13/15 at 12:59 p.m., the outside environmental temperature was in the mid-ninety degrees Faherenheit with a dew point of 72 degrees Faherenheit. The facility's roof-top air conditioning unit was being replaced that day resulting in the kitchen being warmer and more humid that normal conditions. This was an isolated event of over 20 years, since the unit was the original cooling unit for that part of the building. The administrator toured the walk-in freezer after being summoned by the dietary manager regarding the surveyor's concern. There was some mild frosting of on the base of one fan guard. The area measured 1 x 2 inches with no thickness. There was no ice build-up and no ice was blowing over the contained food boxes. The frost on the thermometer disseminated by simply placing a finger on the face of the thermometer. The finding was remedied	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 dishwasher machine temperatures be logged every shift and irregularities reported "immediately." The DM further explained that the booster was supposed to have been turned on in morning before running any dishes through the dishwasher, and then was to be turned off at night. During an interview on 7/16/15, at 10:34 a.m. the director of maintenance stated the hot water temperatures was set at 160 degrees. If the booster was turned off, the director of maintenance said the water would not heat to the required 180 degrees temperature for the final rinse. The Hatco Corporation Electric Booster Water Heater's Installation and Operation Manual dated 2013 directed that, "Turn on the booster water heater...when the booster water heater has had sufficient heating time, operate the rinse cycle and check the water temperature and pressure readings on the gauges. Water temperature at the booster outlet should be 185-190 degrees F (85-86 degrees Centigrade)...." On 7/13/15, at 12:59 p.m. during the initial kitchen tour, the two fan guards, thermostat and some food boxes in the kitchen walk-in freezer were covered with frost build up. The fans were blowing the ice all over the food boxes. The DM verified the findings at the time of the observation. On 7/15/15, at 9:39 a.m. the freezer and refrigerator by the nurse's desk/kitchenette area, juice was spilled and had not been wiped clean from the bottom shelf of the refrigerator. The small freezer on top of the refrigerator was covered with built-up ice/frost in the inside. The	F 371	later in the afternoon when the new roof-top unit was operational. This finding was an isolated event which was unavoidable upon analysis of causative factors. The freezer/refrigerator near the kitchenette area referenced in the example to have an orange juice spill and frosted freezer on 7/15/15 was an isolated finding which posed no immediate health risks. The facility does have a Refrigerator Cleaning Policy and Procedure which speaks to cleaning the refrigerators on a 'as needed routinely.' The frost build-up on the communal freezer may have resulted from miscommunication between nursing and maintenance staff as to the need for the freezer to be defrosted. When this issue was brought to facility staff's attention, maintenance staff removed the unit to have it defrosted. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. In addition to the dietary manager's immediate response to the aforementioned findings, the dietary manager will continue to personally train each new dietary team member on turning on the booster heater and making sure it is on for each shift. In addition, the dietary manager will continue to train her staff on checking dishwasher temperatures every shift and report irregularities to her immediately. In addition, the dietary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 6 findings were verified by a registered nurse (RN)-A at the time of the observation. RN-A stated that night shift was responsible for deep cleaning of refrigerator, "but it's a communal responsibility" to make sure the refrigerator was kept clean. RN-A stated that she did not know who was responsible for defrosting the freezer. During interview on 7/15/15, at 10:32 a.m. the director of nursing (DON) stated that she did not know who was responsible for defrosting the freezer, but said "I will check and let you know." The DON stated her expectations were that staff will cleaned the freezers and refrigerators as per the schedule and as needed. The following day at 12:50 p.m. the DON stated that she did not have "anything written down" but the maintenance director usually defrosted the freezer every six months. The undated Auburn Manor Refrigerator Cleaning Policy and Procedure indicated, "Refrigerators in resident's rooms, kitchenette area, and med [medication] room will be cleaned as needed routinely to reduce the spread of infection."	F 371	manager will continue to monitor the temperature logs for completion daily. 2. The facility's Refrigerator Cleaning Policy and Procedure has been updated to include the defrosting of the communal kitchenette refrigerator at least every six months and as needed. The defrosting of the freezer has been added to the automated electronic (TELS) maintenance preventative maintenance schedule. The health unit coordinator will be responsible for the day to day monitoring for everyone's compliance with the requirements of the sanitation of the refrigerator/freezer. 3. Ongoing: Quarterly random sample audits of dishwasher temperatures and the kitchenette refrigerator/freezer sanitation will be conducted and incorporated into the facility's quality assurance program. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 7 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly administer medication from an inhaler according to manufacture's guidelines for 1 of 1 resident (R61) whose inhaler administration was observed. Findings include: R61's Symbicort inhaler (for asthma) was administered on 7/14/15, at 10:00 a.m. a trained medication assistant (TMA)-A. While shaking the inhaler as required prior to administration TMA-A asked R61, "Are you ready?" R61 took a puff from the inhaler and breathed in the medication. TMA-A then shook the inhaler, and without waiting in between puffs, administered a second puff to R61 who then breathed in the medication. TMA-A had not instructed the resident to exhale prior to breathing in either puff, to hold his breath following the two puffs, and did not wait a full minute between puffs to allow the medication to expand the airway and provide full benefit of the	F 425	It is the policy, and intention, of Auburn Manor in Chaska to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility□'s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. Auburn Manor provides routine and emergency drugs and biologicals to its	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 8 medication. Following the observation TMA-A stated, "I think I am to wait 30 seconds before administering the second puff...That's how I was showed to give it." On 7/14/15, at 10:12 a.m. a licensed practical nurse (LPN)-A was asked about R21's inhaler medication. She reported, "I normally wait about one minute before each puff of the inhaler. LPN-A also stated, "The TMAs usually give the inhalers...I instruct the resident to breathe out before breathing in the inhalation and hold breath for as long as they can." At 10:14 a.m. director of nursing stated, "I would expect TMAs to know how to give the inhaler by the packaging or from notes." When asked for a policy regarding inhalers on 7/15/15, at 9:22 a.m. the director of nursing stated she expected staff to follow manufacture's guidelines when administering inhalers. The undated Orally Inhaled Medications policy directed the staff to "Explain steps to resident: Have resident exhale fully--shake unit to disperse medication--place mouthpiece in front of mouth or in mouth according to manufacturer's recommendations--while inhaling slowly and deeply through mouth, depress medication canister fully. Have resident hold breath for 10 seconds OR as long as possible OR according to manufacturer's recommendations. Have resident exhale through pursed lips...Wait approximately 1 minute between puffs OR as ordered by physician OR according to manufacturer's recommendations."	F 425	residents, or obtains them under an agreement described in ¿483.75(h) of this part. The facility does permit unlicensed personnel to administer drugs as permitted by State law, under the general supervision of a licensed nurse. Resident #61 has a long-standing history of controlling his asthma with Symbicort. He has been receiving the Symbicort inhaler since his admission last January. Resident #61 is very familiar with the inhaler administration protocol. He does not require daily reminders of when to breathe in, when to hold his breath and when to exhale as someone new to the protocol or someone with a cognitive impairment may. Those basic instructions are not appropriate or dignified for R61. His MDS scores in Section C would support his cognitive function and ability to understand a consistent medication administration protocol without repeated elementary instructions of when to breathe in and when to breathe out. Resident #61's MDS Section C accompanies this document (Appendix F). Upon further review of the manufacturer's instructions found at their website, https://www.mysymbicort.com/asthma/symbicortinhaler/symbicort-inhaler.html, the only time required between puffs of symbicort is the time required to re-shake the inhaler, which the TMA did. The TMA followed the manufacurer's guidelines, as the facilty policy instructed. It is the facility's position that no deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9	F 425	practice occurred at F 425 and is exercising it's right to request an Informal Dispute Resolution (IDR) review. Unfortunately, that process exceeds the required time frame allowed for an acceptable plan of correction, even though the facility's position is that there was not a deficient practice at F 425. As a result, the following plan has been implemented while the facility awaits the results of the IDR. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Trained medication aides will receive an education refresher on medication administration with an emphasis on orally inhaled medication administration. 2. Licensed nursing staff responsible for the oversight of the delegated nursing task of medication administration will monitor the ongoing daily functions of medication administration by the trained medication aides. 3. Ongoing: Quarterly random sample audits of medication administration by trained medication aides will be conducted by the pharmacy nurse consultant. The results of those audits will become part of the facility's quality assurance program. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident equipment was clean and stored properly and gloves were disposed of properly for 4 of 4 residents(R11, R16, R48, R63) reviewed for infection control. In addition, staff failed to properly handle dirty linens and use appropriate hand washing and gloving technique for 1 of 1 resident (R31) observed during catheter care. Findings include: During resident room observations on 7/13/15, at 2:30 p.m. R63's commode was located in the resident's room/living area. The lid to the commode was unclean. R63's bed pan was also stored for use on the bathroom floor at the time of the initial observation, as well as during subsequent observations on 7/14/15 and 7/15/15. On 7/13/15, at 4:00 p.m. R16 was sitting in a recliner with a catheter bag positioned on the floor. On 7/13/15, at 4:30 p.m. Subsequent observations on 7/15 and 7/16/15 revealed the measuring graduate for R48's catheter was stored on the bathroom vanity, approximately 12 inches from the resident's toothbrush and toothpaste. In addition R11's toilet insert (for specimen collection) was stored on top of the bathroom sink on 7/15/15, at 8:45 a.m. The toilet cover was soiled and there were used gloves left on the floor in the bathroom. When interviewed on 7/16/15, at 11:45 a.m. the infection control nurse stated all staff had been trained on use of standard precautions for	F 441	Auburn Manor has established and maintains 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. The survey team cited that the facility did not meet the requirement of ensuring that all resident equipment was clean and stored properly and gloves were disposed of properly for four residents. In addition, the survey team cited that in one case, one nursing assistant did not handle soiled linens properly or use appropriate hand washing and gloving technique while providing urinary catheter care. Immediate remedial measures included 'In Time' training on infection control principles, including urinary catheter care, for the staff involved. All bedpans and urinals were immediately placed in appropriate coverings and stored away from clean supplies in all resident rooms. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility direct care staff will receive an educational infection control refresher which will include proper storage of clean resident equipment, appropriate glove disposal, handling of soiled linens, urinary catheter care, and any other infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 infection control. She stated they had policies and procedures on how to store and clean resident equipment, as well as for hand washing and glove usage. She was unaware of the situations described observed as above. An undated Auburn Manor Home & Room order policy noted directed staff to store "no toileting objects should be placed/visual throughout the room and not to store anything on the floor." An undated Catheter Care policy specified staff should "never let the bag touch the floor." A 6/15, Infection Control Program indicated the goal was to maintain compliance with state and federal regulations relating to infection prevention and reporting. The comprehensive infection control program addressed surveillance, prevention, and control of infections among residents and personnel. Findings include: R31 was assisted with catheter cares on 7/16/15 at 9:54 a.m. A nursing assistant, (NA)-C explained the procedure, gathered supplies and raised the bed. NA-C donned gloves and removed the catheter bag from a pillowcase that was hooked to the bed. She reached into her pocket to retrieve an alcohol wipe. NA-C then cleaned the end of the catheter bag, emptied the urine into the toilet and recorded the findings on a clip board explaining she would transcribe the information into the computer when she was finished. NA-C removed her gloves, washed her hands and moved the bed into the low position with a mat on the floor. She then left the room to find a staff member to assist with pericare for R31. At 10:03 she came back into the room and prepared a basin of water and soap which she	F 441	control-related areas of concern. 2. Gelled alcohol dispensers are available in each resident room and is used as an adjunct to hand washing when necessary. The appropriate use of gelled alcohol products will also be discussed at the infection control training sessions. 3. Day-to-day compliance with standard infection control principles will be monitored and enforced by the licensed nursing staff. 4. Ongoing: Quarterly random sample audits of the proper cleaning and storage of residents' equipment will be conducted as part of the Resident and Room Safety audit process. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13	F 441		

placed on the bedside table. She donned gloves and began pericare. She did not wash per hands prior to starting the procedure.

When the task was finished, she placed the soiled wash cloth on the bedside table and removed the incontinent pad, applied barrier cream with a disposable cloth and placed a clean incontinence pad beneath R31. She removed then removed her soiled gloves.

She again donned gloves without washing her hands, took a fresh wash cloth from the basin and assisted R31 to wash and dry her face and upper body. Na-C proceeded to the closet and drawers to pick out clothing. Her gloves were still intact. After R31 was dressed, NA-C took the mouthpiece from the headset into her gloved hands to ask for assistance to transfer R31 into her recliner. When help arrived, NA-E assisted NA-C to transfer R31 into her recliner with the use of a lift. After R31 was positioned in her chair, NA-E placed the pillowcase containing the catheter on the floor. She removed her gloves and left the room.
NA-C took the dirty washcloths and placed in a plastic bag, emptied the basin and removed her gloves

When task was completed, NA-C stated, "I got clumsy and didn't wash my hands." She further explained she knew that when she put the dirty wash cloth on the bedside table, "It was wrong." She verified she did not clean the bedside table after the soiled wash cloth had been removed.

During an interview on 7/13/15, at 1:46 p.m., a registered nurse, RN-B stated R1 has a history of urinary tract infections, one since indwelling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14	F 441		

catheter was placed when admitted to the hospital on 5/24/15 after a fall. A urinary infection was noted 6/3/15.

A nursing note dated 7/14/15, noted the collection of urine for a urinary analysis'
A nursing note dated 7/15/15 noted new orders for an antibiotic (Cipro) for R31.

R31 ' s diagnosis listed on careher care plan dated 6/16/15 included: history of urinary infection, infection due to indwelling urine catheter, urine retention and chronic kidney disease.

The care plan dated 6/16/15 directs staff to monitor for signs and symptoms of urinary tract infection (UTI) prn, assist with pericare and toileting and to provide catheter cares per house policy.

During an interview on 7/16/15, at 10:42 a.m. the director of nursing (DON) stated she expected staff would not place a washcloth used for pericare on a bedside table and for staff to wash hands before and after a procedure. However, she was unclear if if staff was expected to wash their hands before and after gloving or when proceeding from a dirty to clean procedure, "There has been new training on this and I will need to see what our policy says." After review of the facility's policy and procedures regarding handwashing, gloving, pericare and catheter care, the DON explained she did expect staff to wash their hands before and after gloving and when going from a dirty to clean procedure.

During an interview on 7/16/15, at 11:00 a.m. the infection control nurse, RN-C stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 expected infection control precautions were performed by all staff during pericare and catheter care, including not placing equipment such as catheters on the floor or dirty linen on bedside table. She also expected staff to wash their hands before and after using gloves. She explained staff is trained on an on-going basis in these areas The Auburn Manor Catheter Care/Perineal Care, undated, directs staff sanitize hands and don gloves before coming in contact with linen, incontinent pad, and/or resident. Finish by disposing of soiled linen/product/equipment appropriately. Wash hands. The Auburn Manor in service guidelines for Pertinent Perineum care, undated directs staff go from clean to dirty, never from dirty to clean, wash hands and apply gloves before to procedure. After pericare the staff is directed to remove gloves and wash hands properly.	F 441		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245604	A. Building B. Wing	9/8/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/08/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/08/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/08/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/mm	11/16/2015	30923	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/16/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WSUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/16/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **61** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 08/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 27, 2015

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

RE: Project Number S5604025

Dear Mr. Krant:

On July 16, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
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 August 25, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 25, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 16, 2015 (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 January 16, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
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
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct an assessment to determine the appropriate use of a defined perimeter mattress (with raised edges) as a potential restraint for 2 of 5 residents (R38, R23) reviewed for potential restraint use. Findings include: R38 was observed seated in a recliner in her room on 7/14/15, at 9:36 p.m. R38's feet were up, her call light was within reach, and a wheeled walker was out of her reach and nearby the bed.	F 221	It is the policy, and intention, of Auburn Manor in Chaska to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid 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	8/25/15

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

Electronically Signed | 08/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 The bed had a defined perimeter mattress. On 7/16/15, at 8:38 a.m. R38 was observed lying in bed on her back. She was lying on her left side and her left leg was hanging over the edge of the mattress. R38's MDS dated 5/8/15, indicated R38 was unsteady, was only able to stabilize self with staff assistance when moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. R38's current NA care sheet carried by the NAs to outline resident care needs indicated R38 had a history of falls with hip fracture. On 7/15/15, various staff were interviewed. At 5:22 p.m. NA-I reported R38 was able to get herself out of the recliner, and "if she wanted to" she could get out of bed herself. NA-I also stated R38 was supposed to, however, use assistance from one staff person. NA-G was interviewed at 7:51 p.m. NA-G explained that R38 had "a hard time getting out of bed because of the mattress...she tries to get out," but the most she could do was sit on the side of the bed. NA-G said R38 needs a "boost up," and that the resident had not fallen recently. A trained medication aide (TMA)-A then stated at 8:07 a.m. that R38 needed limited assistance from one staff, and "just needed a boost up...she can get out of the chair herself. It's not that she can't, it's just harder for her." TMA-A also stated R38 could not get out of bed by herself and if R38 wanted help she would yell and call out, and she would forget to use her call light.	F 221	Correction is not an admission that adeficiency 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. Residents of Auburn Manor have the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. It is the position of Auburn Manor that physical restraints are not used on any of its residents. Although not part of the deficiency statement at F 221, it is important to note that Resident #38 was assessed for independent use of her recliner on 3/17/15. The aforementioned assessment is included in Appendix A of this document. Resident #23 has been assessed for the use of a recliner also. A copy of that assessment which supports his ability to independently use the recliner with no restriction of his movement can be found in Appendix C. The resident is able to use the electronic control, but demonstrates poor judgment. The resident's wife was involved in the decision to allow the resident to have full control of the remote which operates the chair. The recliner has been determined not to impose upon his freedom of movement or normal access to his body.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 At 8:18 a.m. NA-C stated R38 could get out of recliner and bed herself, but was "not supposed to," and was to do so only with help from staff. On 7/15/15, at 8:23 a.m. RN-C verified there was no assessment demonstrating the perimeter mattress and recliner were not a potential restraint for R38. RN-C also stated the RN's completed restraint assessments. At 8:39 a.m. NA-F stated R38 required staff assistance for transferring. NA-F stated she was sure R38 could get out of bed herself but was not supposed to do so. RN-D then stated at 8:41 a.m that usually a nurse or therapy staff completed restraint assessments. RN-D verified there was no assessment completed for R38 and stated, "No, we not do restraint assessments for bolster [perimeter] mattresses. We have not done them in the past and we have never been asked to do restraint assessments for bolster mattresses." RN-D verified R38's bolster mattress was applied and added to the care plan on 10/14/14, because of a fall on 10/13/14. R23's bed was observed with a defined perimeter mattress on 7/13/15, at 6:30 p.m. A recliner was in the resident's room. The following day at 3:10 p.m. R23 was observed sitting in a recliner with his feet up, with the call light on arm of chair, and a mat on the floor in front of his feet. On 7/14/15, at 9:43 a.m. NA-H reported R23 needed staff assistance to get out of bed, and R23 was unable to get out of bed independently. On 7/15/15, at 7:54 a.m. NA-G stated R23	F 221	Although a designated form encapsulating all of the ongoing assessment activities of both residents in this example may not be found in either medical record, it is important to note that multiple assessments supporting the use of the perimeter mattresses and recliners existed. The critical thinking nurse must be able to analyze all data collected regarding mobility status as supported by Section G of the MDS, fall history, physical and occupational therapy assessments, and quality of life outcomes (including freedom of injury from falls out of bed) when determining whether any device has the effect of restraining the resident. Professional assessments by the nurse as well as the entire clinical team are ongoing and reflected in progress notes and throughout the resident's medical record. All of the gathered resident assessment data, which is fluid in nature and not just based upon one specific assessment completed at a given point in time, much like the one the survey team referenced in their example, is used daily to determine appropriate adaptive resident devices usage and the prevention of restricting resident movement or access to their bodies (physical restraints.) No where in the interpretive guidelines at F 221 does it dictate that a specific, one page, assessment form be present in the resident's medical record to support the use of a perimeter mattress or to identify possible physical restraints.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3 transferred with an EZ Stand and one staff assist from staff, and alarms were utilized on R23's chair and bed. NA-G stated R23 had not transferred himself "again" and that she thought R23 had become "scared after his last fall" when he self-transferred with a family member. At 8:58 a.m. NA-F then stated R23 had not self-transferred again, as he now has "gotten all the bells and whistles" (alarms). At 10:38 a.m. NA-G stated R23 could not transfer himself out of bed, and does not even try to do so. NA-G also stated R23 once put his recliner chair up high and was "kind of standing but then the mat on the floor has alarms." NA-G further stated she did not know when the perimeter mattress was put on R23's bed. R23's MDS dated 4/10/15, indicated the resident was unsteady, was only able to stabilize with staff assistance when moving from seated to standing position, walking, turning, moving on and off toilet, and surface to surface transfers. R23's care plan indicated he was at risk for falling, as well as a history of falls and self-transfers. The goal was for R23 to remain free of injury from falling. Progress notes revealed R23 experienced an unwitnessed fall on 1/24/15, at 10:10 p.m. The resident was found in his room, crawling out of bed. The resident was found kneeling on the sensor mat, which was alarming. On 7/15/15, at 10:38 a.m. a licensed practical nurse (LPN)-B verified the staff had not completed an assessment to demonstrate the	F 221	Based upon this misrepresentation, and the information shared above, the facility's position is that no deficient practice occurred at F 221 and the facility will exercise it's right to initiate the Informal Dispute Resolution (IDR) process. Unfortunately, that process exceeds the required time frame allowed for an acceptable plan of correction, even though the facility's position is that there was not a deficient practice at F 221. As a result, the following plan has been implemented while the facility awaits the results of the IDR review. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. The facility has adopted a Device Decision Guide published by Primaris (Appendix D1) as an additional assessment tool which compliments what the facility already has un place. The guide and protocol will be utilized whenever the IDT contemplates initiating a resident adaptive device to ensure that the device does not meet the criteria of a physical restraint both before its implementation and on an ongoing basis or if the resident's status changes. An example of that tool accompanies this document under Appendix E. Facility licensed nursing staff will be educated on the tool at the next licensed nursing staff meeting on August 24, 2015. 2. Both residents in the example will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4 perimeter mattress and the recliner were not potentially restraints for R23. On 7/16/15, at 8:48 a.m. RN-C reported, "We do not do restraint assessments here for bolster mattresses." The DON then stated at 9:22 a.m. "We have not thought of bolster mattresses as a potential restraint. We have put the mattresses in as fall interventions." The administrator reported in an interview at 1:33 p.m. when asked about restraints, "If it does not meet a physical restraint definition, we do not treat it as a restraint." The administrator also stated, "Often times it is based on the residents' mobility, their ability to use devices or a history of rolling out of bed. We just use it [perimeter mattress] as a gentle reminder." The administrator reported the facility had not considered Bolster mattress as potential restraining for a resident. He provided a CMS document which read, "Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint." The undated Use of Restraints policy indicated "Auburn Homes and Services recognizes the importance of a resident's dignity and safety. Any form of restraint will not be the first intervention when meeting the individual needs of the resident and will be used as minimally as possible.	F 221	assessed using the above guide and protocol. 3. Ongoing: Quarterly random sample audits of residents with adaptive equipment will occur for not less than one year from date certain. The focus of these audits will be to validate that the required assessments and documentation exist in the resident's medical record to support the use of the adaptive equipment and to ensure that the equipment is not functioning as a physical restraint. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5 Physical and chemical restraints will be used only to treat specific medical symptoms or in an emergency situation to protect residents or others from eminent danger. ...'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body...."	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was within reach for 1 of 2 (R21) residents reviewed for environmental concerns. Findings include: On 7/13/15, at 2:45 p.m. R21 was observed lying on her back with the head of the bed raised slightly, watching a television. Her call light was next to her on the bed, which she was able to locate with verbal cues from the surveyor. Later that evening at 7:14 p.m. R21 was in her	F 246	Auburn Manor respects each resident's right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The survey team cited one instance when they 0bserved R21's call light to be on the floor and out of reach of the resident. This resident is known to become restless and will throw her call light on the floor at times. Contributing factors to this finding	8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 6 room sitting in her wheelchair next to her bed. The doors to her room were open, and the resident could be visualized from the hallway. She was dressed in a T-shirt and incontinence brief and her bare legs were out in front of her on the chair leg rest. She was reaching toward the bed with her left hand. The call light was out of the resident's reach on the floor behind the wheelchair. At 7:17 p.m. a nursing assistant (NA) came into the room and asked R21 what she could do to help. Without picking up the call light, the NA hurriedly left R21's room stating, "I'll be right back." At 7:20 p.m. the NA came down the hall with a second NA, but instead of returning to R21's room, the two NAs went into the adjacent resident room. At 7:28 p.m. the surveyor asked a registered nurse (RN)-A to observe the location of R21's call light. RN-A picked up the light and verified it should not have been left on the floor out of R21's reach. She explained, "She is fidgety and she probably threw it off her. They [NAs] should have pinned it on her chair," which RN-A then did. RN-A said R21 probably could not have used the call light effectively, and added she was normally, "under staff eyes when up in the wheelchair during the day." RN-A said R21 was admitted after a fall with hip fracture, and had experienced one fall at the facility. R21 had been newly admitted to the facility from the hospital. The initial Minimum Data Set revealed the resident had been experiencing delirium symptoms (an acute abnormal mental state often associated with infection) with fluctuating cognition. On 7/15/15, at 9:52 a.m. NA-F stated R21 was	F 246	includes the call light's cord clip failing from, what more than likely was, the force of the resident's pulling on the cord and throwing it. This was an isolated event supported by the number of other times the surveyor described the call light being within the resident's reach as noted in the example. This event was incidental in nature and not a result of a failed practice or facility system. Residents' call lights being within reach is the standard of care at Auburn Manor and all staff understand the importance and necessity of this. The call light cord clip was replaced immediately upon its discovery and had been noted to be functioning properly during the remainder of the survey, again as noted throughout the surveyor's example. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility staff will be provided a reminder of the necessity to ensure that resident's call lights are always within the resident's reach. This will be accomplished using the facility's electronic learning system. 2. Charge nursing personnel will be responsible for ongoing compliance of call lights being within reach by doing visual monitoring of resident room's for appropriate call light placement. 3. Ongoing: Quarterly random sample audits of correct call light placement will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 7 able to use her call light and did use her call light. NA-F also stated in fact, "Sometimes she gets 'call light happy.'" NA-F further stated when R21 was out of her room, the call light was clipped to the bed and when R21 sat in her recliner, staff clipped the call light to the recliner. At time of interview R21's call light was observed clipped onto the bed sheet at the head of R21's bed. On 7/15/15, at 11:35 a.m. the director of nursing (DON) was interviewed. She explained that residents who were unable to use their call lights would have been out of their rooms "where staff can see them...staff should round on them to see if they have any needs during the night, or naps in bed during the daytime." She added, "I would expect that to show in the care plan. It's not likely to be in the policy. Specific rounding times should be in the care plan." When asked whether call light audits had been performed she said she would need to speak to the director of maintenance, "because he does more of the technical side." Since she took over the position of director of nursing 5/18/15, DON stated she had not performed any call light audits. The DON also stated she expected staff to follow facility policies. In addition, she expected call lights to be placed in reach of residents who were able to use them. When asked if she would expect care plans to indicate whether a resident could not use the call light she responded, "No, I have not had that expectation because...my thought is that they are always in reach."	F 246	be conducted utilizing the facility's Resident and Room Safety Audit Tool (Appendix E). Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 8 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow procedures to ensure that sanitation occurred during the dishwashing process and consistently monitor dishwasher temperatures. In addition, the facility failed to ensure that freezers and refrigerators were kept clean and that opened food was dated. This had the potential to affect all 60 residents that resided in the facility. Findings include: On 7/14/15, at 9:56 a.m. during a follow-up tour of the kitchen, a dietary aide (DA)-A was observed running dishes through the dishwasher. The wash tank temperature was noted to be 132 degrees Fahrenheit (F), the rinse tank temperature at 142 degrees F and the final rinse temperature was 132 degrees F. DA-A ran about four additional loads of plates through the dishwasher machine and the temperatures remained the same as above. At the same time, DA-B was taking dishes sent through the dish machine and began storing them for use. The surveyor intervened and asked DA-A to look at the dishwasher temperature gauge and verify it was not heating to the required temperatures.	F 371	Auburn Manor does procure food from sources approved or considered satisfactory by Federal, State and local authorities and stores, prepares and distributes that food under sanitary conditions. On 7/14/15, the survey team noted that the dishwasher in the kitchen was not heating to required temperatures. The facility's dietary manager was consulted and determined that the dishwasher booster heater had been turned off. Contributing factors to this finding included a new dietary staff member being involved in the finding. The dietary aid stated that she was nervous with the survey process and forgot to turn on the booster heater. Once the booster heater was turned on and the water temperatures reached required levels, all dishes that would have been affected by the water temperatures not reaching required levels were re-washed at the proper temperatures. This was directed by the facility's dietary manager and not the surveyor as stated in the example.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 Following the observation, DA-A stated that she expected the washer temperatures to be between 150-160 degrees and the final rinse temperatures to be above 180 degrees. DA-A reported she had checked the temperatures "this morning before breakfast and the machine was working okay." On 7/14/15, at 10:11 a.m. the dietary manager (DM) verified that the dishwasher temperatures were 142 degrees F for the wash cycle and 132 degrees F for the final rinse. DM stated that "the booster might be off." The DM then checked on the booster and verified that it had been turned off. She turned the booster on and asked DA-A to run empty trays through the dishwasher machine. After running three empty trays, the wash temperature was recorded at 152 degrees F and the final rinse at 190 degrees F. The surveyor then requested the dishes previously washed be re-washed at the proper temperature. The 7/15, dish machine temperature log was reviewed on 7/13/15, at 1:13 p.m. The log revealed temperatures were supposed to have been recorded three times daily at breakfast, lunch and dinner. Data was unrecorded for three days for breakfast, four days for lunch and seven days for dinner between 7/1 and 7/13/15. The DM verified the inconsistencies in monitoring of the dishwasher temperatures. During a follow-up interview on 7/15/15, at 12:57 p.m. the DM reported all dietary employees had been trained on using dishwasher and how to log temperatures. Here expectations were that dishwasher machine temperatures be logged every shift and irregularities reported "immediately." The DM further explained that the booster was supposed to have been turned on in	F 371	In response to the above findings, the dietary manager is personally training each new dietary team member on turning on the booster heater and making sure it is on for each shift. In addition, the dietary manager has re-trained her staff on checking dishwasher temperatures every shift and report irregularities to the dietary manager immediately. In addition, the dietary manager monitors the temperature logs for completion daily. During the initial tour of the kitchen, on 7/13/15 at 12:59 p.m., the outside environmental temperature was in the mid-ninety degrees Faherenheit with a dew point of 72 degrees Faherenheit. The facility's roof-top air conditioning unit was being replaced that day resulting in the kitchen being warmer and more humid that normal conditions. This was an isolated event of over 20 years, since the unit was the original cooling unit for that part of the building. The administrator toured the walk-in freezer after being summoned by the dietary manager regarding the surveyor's concern. There was some mild frosting of on the base of one fan guard. The area measured 1 x 2 inches with no thickness. There was no ice build-up and no ice was blowing over the contained food boxes. The frost on the thermometer disseminated by simply placing a finger on the face of the thermometer. The finding was remedied later in the afternoon when the new roof-top unit was operational. This finding was an isolated event which was unavoidable upon analysis of causative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 morning before running any dishes through the dishwasher, and then was to be turned off at night. During an interview on 7/16/15, at 10:34 a.m. the director of maintenance stated the hot water temperatures was set at 160 degrees. If the booster was turned off, the director of maintenance said the water would not heat to the required 180 degrees temperature for the final rinse. The Hatco Corporation Electric Booster Water Heater's Installation and Operation Manual dated 2013 directed that, "Turn on the booster water heater...when the booster water heater has had sufficient heating time, operate the rinse cycle and check the water temperature and pressure readings on the gauges. Water temperature at the booster outlet should be 185-190 degrees F (85-86 degrees Centigrade)...." On 7/13/15, at 12:59 p.m. during the initial kitchen tour, the two fan guards, thermostat and some food boxes in the kitchen walk-in freezer were covered with frost build up. The fans were blowing the ice all over the food boxes. The DM verified the findings at the time of the observation. On 7/15/15, at 9:39 a.m. the freezer and refrigerator by the nurse's desk/kitchenette area, juice was spilled and had not been wiped clean from the bottom shelf of the refrigerator. The small freezer on top of the refrigerator was covered with built-up ice/frost in the inside. The findings were verified by a registered nurse (RN)-A at the time of the observation. RN-A stated that night shift was responsible for deep cleaning of refrigerator, "but it's a communal	F 371	factors. The freezer/refrigerator near the kitchenette area referenced in the example to have an orange juice spill and frosted freezer on 7/15/15 was an isolated finding which posed no immediate health risks. The facility does have a Refrigerator Cleaning Policy and Procedure which speaks to cleaning the refrigerators on a 'as needed routinely.' The frost build-up on the communal freezer may have resulted from miscommunication between nursing and maintenance staff as to the need for the freezer to be defrosted. When this issue was brought to facility staff's attention, maintenance staff removed the unit to have it defrosted. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. In addition to the dietary manager's immediate response to the aforementioned findings, the dietary manager will continue to personally train each new dietary team member on turning on the booster heater and making sure it is on for each shift. In addition, the dietary manager will continue to train her staff on checking dishwasher temperatures every shift and report irregularities to her immediately. In addition, the dietary manager will continue to monitor the temperature logs for completion daily. 2. The facility's Refrigerator Cleaning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 responsibility" to make sure the refrigerator was kept clean. RN-A stated that she did not know who was responsible for defrosting the freezer. During interview on 7/15/15, at 10:32 a.m. the director of nursing (DON) stated that she did not know who was responsible for defrosting the freezer, but said "I will check and let you know." The DON stated her expectations were that staff will cleaned the freezers and refrigerators as per the schedule and as needed. The following day at 12:50 p.m. the DON stated that she did not have "anything written down" but the maintenance director usually defrosted the freezer every six months. The undated Auburn Manor Refrigerator Cleaning Policy and Procedure indicated, "Refrigerators in resident's rooms, kitchenette area, and med [medication] room will be cleaned as needed routinely to reduce the spread of infection."	F 371	Policy and Procedure has been updated to include the defrosting of the communal kitchenette refrigerator at least every six months and as needed. The defrosting of the freezer has been added to the automated electronic (TELS) maintenance preventative maintenance schedule. The health unit coordinator will be responsible for the day to day monitoring for everyone's compliance with the requirements of the sanitation of the refrigerator/freezer. 3. Ongoing: Quarterly random sample audits of dishwasher temperatures and the kitchenette refrigerator/freezer sanitation will be conducted and incorporated into the facility's quality assurance program. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 12 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly administer medication from an inhaler according to manufacture's guidelines for 1 of 1 resident (R61) whose inhaler administration was observed. Findings include: R61's Symbicort inhaler (for asthma) was administered on 7/14/15, at 10:00 a.m. a trained medication assistant (TMA)-A. While shaking the inhaler as required prior to administration TMA-A asked R61, "Are you ready?" R61 took a puff from the inhaler and breathed in the medication. TMA-A then shook the inhaler, and without waiting in between puffs, administered a second puff to R61 who then breathed in the medication. TMA-A had not instructed the resident to exhale prior to breathing in either puff, to hold his breath following the two puffs, and did not wait a full minute between puffs to allow the medication to expand the airway and provide full benefit of the medication. Following the observation TMA-A stated, "I think I am to wait 30 seconds before administering the	F 425	It is the policy, and intention, of Auburn Manor in Chaska to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility□'s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. Auburn Manor provides routine and emergency drugs and biologicals to its residents, or obtains them under an agreement described in ¿483.75(h) of this part. The facility does permit unlicensed personnel to administer drugs as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 13 second puff...That's how I was showed to give it." On 7/14/15, at 10:12 a.m. a licensed practical nurse (LPN)-A was asked about R21's inhaler medication. She reported, "I normally wait about one minute before each puff of the inhaler. LPN-A also stated, "The TMAs usually give the inhalers...I instruct the resident to breathe out before breathing in the inhalation and hold breath for as long as they can." At 10:14 a.m. director of nursing stated, "I would expect TMAs to know how to give the inhaler by the packaging or from notes." When asked for a policy regarding inhalers on 7/15/15, at 9:22 a.m. the director of nursing stated she expected staff to follow manufacture's guidelines when administering inhalers. The undated Orally Inhaled Medications policy directed the staff to "Explain steps to resident: Have resident exhale fully--shake unit to disperse medication--place mouthpiece in front of mouth or in mouth according to manufacturer's recommendations--while inhaling slowly and deeply through mouth, depress medication canister fully. Have resident hold breath for 10 seconds OR as long as possible OR according to manufacturer's recommendations. Have resident exhale through pursed lips...Wait approximately 1 minute between puffs OR as ordered by physician OR according to manufacturer's recommendations."	F 425	permitted by State law, under the general supervision of a licensed nurse. Resident #61 has a long-standing history of controlling his asthma with Symbicort. He has been receiving the Symbicort inhaler since his admission last January. Resident #61 is very familiar with the inhaler administration protocol. He does not require daily reminders of when to breathe in, when to hold his breath and when to exhale as someone new to the protocol or someone with a cognitive impairment may. Those basic instructions are not appropriate or dignified for R61. His MDS scores in Section C would support his cognitive function and ability to understand a consistent medication administration protocol without repeated elementary instructions of when to breathe in and when to breathe out. Resident #61's MDS Section C accompanies this document (Appendix F). Upon further review of the manufacturer's instructions found at their website, https://www.mysymbicort.com/asthma/symbicortinhaler/symbicort-inhaler.html, the only time required between puffs of symbicort is the time required to re-shake the inhaler, which the TMA did. The TMA followed the manufacurer's guidelines, as the facilty policy instructed. It is the facility's position that no deficient practice occurred at F 425 and is exercising it's right to request an Informal Dispute Resolution (IDR) review. Unfortunately, that process exceeds the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 14	F 425	required time frame allowed for an acceptable plan of correction, even though the facility's position is that there was not a deficient practice at F 425. As a result, the following plan has been implemented while the facility awaits the results of the IDR. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Trained medication aides will receive an education refresher on medication administration with an emphasis on orally inhaled medication administration. 2. Licensed nursing staff responsible for the oversight of the delegated nursing task of medication administration will monitor the ongoing daily functions of medication administration by the trained medication aides. 3. Ongoing: Quarterly random sample audits of medication administration by trained medication aides will be conducted by the pharmacy nurse consultant. The results of those audits will become part of the facility's quality assurance program. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 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 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:	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 Based on observation, interview and document review, the facility failed to ensure resident equipment was clean and stored properly and gloves were disposed of properly for 4 of 4 residents(R11, R16, R48, R63) reviewed for infection control. In addition, staff failed to properly handle dirty linens and use appropriate hand washing and gloving technique for 1 of 1 resident (R31) observed during catheter care. Findings include: During resident room observations on 7/13/15, at 2:30 p.m. R63's commode was located in the resident's room/living area. The lid to the commode was unclean. R63's bed pan was also stored for use on the bathroom floor at the time of the initial observation, as well as during subsequent observations on 7/14/15 and 7/15/15. On 7/13/15, at 4:00 p.m. R16 was sitting in a recliner with a catheter bag positioned on the floor. On 7/13/15, at 4:30 p.m. Subsequent observations on 7/15 and 7/16/15 revealed the measuring graduate for R48's catheter was stored on the bathroom vanity, approximately 12 inches from the resident's toothbrush and toothpaste. In addition R11's toilet insert (for specimen collection) was stored on top of the bathroom sink on 7/15/15, at 8:45 a.m. The toilet cover was soiled and there were used gloves left on the floor in the bathroom. When interviewed on 7/16/15, at 11:45 a.m. the infection control nurse stated all staff had been trained on use of standard precautions for infection control. She stated they had policies and procedures on how to store and clean resident	F 441	Auburn Manor has established and maintains 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. The survey team cited that the facility did not meet the requirement of ensuring that all resident equipment was clean and stored properly and gloves were disposed of properly for four residents. In addition, the survey team cited that in one case, one nursing assistant did not handle soiled linens properly or use appropriate hand washing and gloving technique while providing urinary catheter care. Immediate remedial measures included 'In Time' training on infection control principles, including urinary catheter care, for the staff involved. All bedpans and urinals were immediately placed in appropriate coverings and stored away from clean supplies in all resident rooms. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Facility direct care staff will receive an educational infection control refresher which will include proper storage of clean resident equipment, appropriate glove disposal, handling of soiled linens, urinary catheter care, and any other infection control-related areas of concern.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 equipment, as well as for hand washing and glove usage. She was unaware of the situations described observed as above. An undated Auburn Manor Home & Room order policy noted directed staff to store "no toileting objects should be placed/visual throughout the room and not to store anything on the floor." An undated Catheter Care policy specified staff should "never let the bag touch the floor." A 6/15, Infection Control Program indicated the goal was to maintain compliance with state and federal regulations relating to infection prevention and reporting. The comprehensive infection control program addressed surveillance, prevention, and control of infections among residents and personnel. Findings include: R31 was assisted with catheter cares on 7/16/15 at 9:54 a.m. A nursing assistant, (NA)-C explained the procedure, gathered supplies and raised the bed. NA-C donned gloves and removed the catheter bag from a pillowcase that was hooked to the bed. She reached into her pocket to retrieve an alcohol wipe. NA-C then cleaned the end of the catheter bag, emptied the urine into the toilet and recorded the findings on a clip board explaining she would transcribe the information into the computer when she was finished. NA-C removed her gloves, washed her hands and moved the bed into the low position with a mat on the floor. She then left the room to find a staff member to assist with pericare for R31. At 10:03 she came back into the room and prepared a basin of water and soap which she placed on the bedside table. She donned gloves and began pericare. She did not wash per hands	F 441	2. Gelled alcohol dispensers are available in each resident room and is used as an adjunct to hand washing when necessary. The appropriate use of gelled alcohol products will also be discussed at the infection control training sessions. 3. Day-to-day compliance with standard infection control principles will be monitored and enforced by the licensed nursing staff. 4. Ongoing: Quarterly random sample audits of the proper cleaning and storage of residents' equipment will be conducted as part of the Resident and Room Safety audit process. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18	F 441		

prior to starting the procedure.

When the task was finished, she placed the soiled wash cloth on the bedside table and removed the incontinent pad, applied barrier cream with a disposable cloth and placed a clean incontinence pad beneath R31. She removed then removed her soiled gloves.

She again donned gloves without washing her hands, took a fresh wash cloth from the basin and assisted R31 to wash and dry her face and upper body. Na-C proceeded to the closet and drawers to pick out clothing. Her gloves were still intact. After R31 was dressed, NA-C took the mouthpiece from the headset into her gloved hands to ask for assistance to transfer R31 into her recliner. When help arrived, NA-E assisted NA-C to transfer R31 into her recliner with the use of a lift. After R31 was positioned in her chair, NA-E placed the pillowcase containing the catheter on the floor. She removed her gloves and left the room.
NA-C took the dirty washcloths and placed in a plastic bag, emptied the basin and removed her gloves

When task was completed, NA-C stated, "I got clumsy and didn't wash my hands." She further explained she knew that when she put the dirty wash cloth on the bedside table, "It was wrong." She verified she did not clean the bedside table after the soiled wash cloth had been removed.

During an interview on 7/13/15, at 1:46 p.m., a registered nurse, RN-B stated R1 has a history of urinary tract infections, one since indwelling catheter was placed when admitted to the hospital on 5/24/15 after a fall. A urinary infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19	F 441		

was noted 6/3/15.

A nursing note dated 7/14/15, noted the collection of urine for a urinary analysis'
A nursing note dated 7/15/15 noted new orders for an antibiotic (Cipro) for R31.

R31 ' s diagnosis listed on careher care plan dated 6/16/15 included: history of urinary infection, infection due to indwelling urine catheter, urine retention and chronic kidney disease.

The care plan dated 6/16/15 directs staff to monitor for signs and symptoms of urinary tract infection (UTI) prn, assist with pericare and toileting and to provide catheter cares per house policy.

During an interview on 7/16/15, at 10:42 a.m. the director of nursing (DON) stated she expected staff would not place a washcloth used for pericare on a bedside table and for staff to wash hands before and after a procedure. However, she was unclear if if staff was expected to wash their hands before and after gloving or when proceeding from a dirty to clean procedure, "There has been new training on this and I will need to see what our policy says." After review of the facility's policy and procedures regarding handwashing, gloving, pericare and catheter care, the DON explained she did expect staff to wash their hands before and after gloving and when going from a dirty to clean procedure.

During an interview on 7/16/15, at 11:00 a.m. the infection control nurse, RN-C stated she expected infection control precautions were performed by all staff during pericare and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	07/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 catheter care, including not placing equipment such as catheters on the floor or dirty linen on bedside table. She also expected staff to wash their hands before and after using gloves. She explained staff is trained on an on-going basis in these areas The Auburn Manor Catheter Care/Perineal Care, undated, directs staff sanitize hands and don gloves before coming in contact with linen, incontinent pad, and/or resident. Finish by disposing of soiled linen/product/equipment appropriately. Wash hands. The Auburn Manor in service guidelines for Pertinent Perineum care, undated directs staff go from clean to dirty, never from dirty to clean, wash hands and apply gloves before to procedure. After pericare the staff is directed to remove gloves and wash hands properly.	F 441		

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

F5604024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division, on July 14, 2015. At the time of this survey, Building 01 of Auburn Manor was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Building 01 of Auburn Manor is a one-story building with no basement. The original building was constructed in 1988, with one building addition constructed in 1992. Both buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 61 beds and had a census of 61 at time of the survey.	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.

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

F5604024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**07/14/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division, on July 14, 2015. At the time of this survey, Building 02 of Auburn Manor was found 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. Building 02 of Auburn Manor consists of a 2006 building addition, which is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The nursing home is separated from an attached assisted living facility by complying two-hour fire wall assemblies. The facility has a capacity of 61 beds and had a census of 61 at time of the survey.	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.